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Leaflet Regarding Rules of Publication.—CALIFORNIA AND WESTERN MEDICINE has prepared a leaflet explaining its rules regarding publication. This leaflet gives suggestions on the preparation of manuscripts and of illustrations. It is suggested that contributors to this Journal write to its office requesting a copy of this leaflet.

DEPARTMENT INDEX

(Itemized Index of Articles is printed on Front Cover)

EDITORIALS†

A NEW-YEAR PRAYER OF TWENTY-FIVE YEARS AGO: BY PHILIP MILLS JONES, FOUNDER-EDITOR OF THE OFFICIAL JOURNAL OF CALIFORNIA MEDICAL ASSOCIATION

Dr. Philip Mills Jones.—Twenty-five years ago, in the *California State Journal of Medicine* (predecessor of CALIFORNIA AND WESTERN MEDICINE), appeared the Greeting for the year 1913, as penned by Dr. Philip Mills Jones, who had founded the Official Journal of the California Medical Association some ten years before. This New Year Prayer is again brought to light, and for several reasons: first, the thoughts therein expressed should have appeal for every physician who loves his profession, and their perusal should be an inspiration for continued service; secondly, it gives us opportunity to call to the attention of present-day members, who may not have known the late Dr. Philip Mills Jones, the splendid record of service and accomplishment he rendered to his beloved "Medical Society of the State of California" (the name by which the California Medical Association was then known); and lastly, because your present editor's early friendship with Doctor Jones permitted him to become intimately acquainted with a colleague who, like the late Dr. George H. Simmons, editor-emeritus of the *Journal of the American Medical Association,* through his broad vision and personality, left an indelible impress upon organized medicine in both his State and the Nation.

* * *

A New-Year Prayer.—We shall print first the New-Year Prayer, and then some excerpts from the pens of physician coworkers who tried to give expression to their regard and grief when, on December 3, 1916, during the influenza epidemic of 1916, death called Doctor Jones from his earthly labors.

* * *

Editorial Salutation in the January, 1913, Issue of the Official Journal.—The greeting in the *California State Journal of Medicine* of twenty-five years ago reads as follows:

†Editorials on subjects of scientific and clinical interest, contributed by members of the California Medical Association, are printed in the Editorial Comment column which follows.

A NEW-YEAR PRAYER

To all of our readers, Greeting! May the year deal kindly with you, and bring you much that is good and little that is of sorrow or trouble; may the spirit of peace and harmony prevail with you throughout the year, and may the mantle of jealousy drop from you as a rag that is worn out; may charity, justice, and brotherly love guide you always in your thoughts of, and your relations with your fellow practitioners of medicine; may it bring an end to bickerings and dissensions, and, departing, may the year leave with you a better-stored mind, contentment with yourself and your fellows, and the inward knowledge, from which comes peace of mind, of a twelvemonth of good, honest work, done with the very best that is in you, and to the betterment of at least a portion of mankind. Give of your time and your brains, the best you have to your medical society, that, in so giving, you may unselfishly help the entire medical profession and the people who are dependent upon it for health and protection; where there is an active and industrious medical society, there will you find good doctors and responsive and grateful patients. Let no word of idle slander or supposititious criticism of a colleague pass your lips; if you cannot speak well of a brother physician, speak not at all, for when you disparage another physician you hurt yourself as well, and the entire profession is belittled in the eyes of the people. May your interest in your medical society work increase with the passing months, and may the year close upon a more closely united and more intimately related medical profession, thus giving to the people of our State the very best medical supervision. May happiness be with you, one and all!

* * *

Tributes on the Occasion of Doctor Jones's Death.—In the October, 1937, issue of CALIFORNIA AND WESTERN MEDICINE, under the caption, "The Passing of a Great Editor: George H. Simmons, 1852-1937," editorial comment was made of the notable services rendered to the American Medical Association and its constituent units by Doctor Simmons. It may be added that all that was said of Doctor Simmons applies, in a general way, with equal force to Dr. Philip Mills Jones, and it is interesting and illustrative of the bigness of heart and outlook of these two men, who became pacemakers in medical journalism and medical organization work in America, that the surface antagonisms and warfare, which existed between them in their earlier years, gave place to a sincere and beautiful friendship when later opportunities permitted them to meet and work with one another; as happened in the many years when Doctor Jones represented California, not only as a member of the American Medical Association House of Delegates, but also as a member of the Board of Trustees of the American Medical Association.

* * *

An Unsigned Editorial.—Below appear first some lines from an unsigned editorial in the January, 1917, issue of the CALIFORNIA STATE JOURNAL OF MEDICINE, on the occasion of Doctor Jones's death:

DR. PHILIP MILLS JONES

"How few of us can do things that others cannot. Were you or I to die tomorrow, what difference would it make? . . .

"Work, that is the thing. And how few do work that others cannot; make things, do or write or say things that others cannot!

"It was strange to pass the State Society's offices; they had that look of the unknown that sudden and shocking events impart to the most ordinary and intimate objects. To hear a typewriter rattling and to think of him who used to dictate—to see files and stacks of letters, malpractice suits and judgments coming in, and to think of him whom they used so vitally to interest. To think that he had woven the JOURNAL, the Medical Defense, and all he had done to bring the profession together, to think of questions critically concerning them, and of what they meant to him—and to us—his work lying undone, and he caring no longer.

"Doctor Jones will be missed. Who is there to do his work? to combine law and medicine and organization talent; to bring to them an even and justly balanced intelligence, industry, and a knowledge of dealing with men.

" 'To be honest, to be kind'—yes—but more than that—'Work while it is called Today; for the Night cometh wherein no man can work.'

"The Night hath come, and we are groping for a guide."

* * *

Tribute from the Late Dr. Harry M. Sherman.—The quotations which follow are taken from a tribute written by the late Harry M. Sherman, beloved physician-surgeon of San Francisco, who in both the years 1914 and 1915 was president of the California Medical Association, sharing that honor of a two-year service with the late Dr. R. F. Rooney of Auburn (president, 1904 and 1905). Read now what Harry Sherman wrote of Doctor Jones's work in cleaning the pages of medical journals of two and three decades ago of off-color advertising, and of bringing about other reforms in organized medicine:

DR. PHILIP MILLS JONES

"It is still a strange thought to me that I have outlived Philip Mills Jones. In the little transient thought that I ever gave to the matter it was natural to think of him as sometime writing about me, dead—it seems almost unnatural for me to be writing about him, dead. . . .

"I came to know him and understand him best at and after this time of the starting of the JOURNAL. No one will doubt for a moment but that the JOURNAL as he left it to us, is the best criterion of the real Phil. Jones. It was never intended to be simply *a journal*, it was intended to be a particular kind of journal, and it has always been such. It has always had a distinct motive—has always followed a thought-out plan. Jones's interest in sociology has tinctured every word he ever wrote for it, and if one reads carefully it is easy to see it running through all his editorial paragraphs and articles. . . .

"Early in the history of the JOURNAL, that is, from 1903 to 1906—both inclusive—George H. Evans and I made, with Jones, a majority of the publication committee. Others who were on the committee with us varied from year to year, but the retention of us three during these four years made a continuous policy a practical thing. Our first big work was the reformation of the advertising methods of the medical press. I say "our first big work," taking to ourselves some of the glory, but Jones did all the writing, got all the obloquy and finally all the praise, while Evans and I merely backed and supported him. The crusade created much bitterness at first, and one famous editor was so much incensed at what was said about his journal that he would neither speak nor write to Jones, and when circumstances made it imperative that there should be some communication I was made the intermediary, the editor writing to me and I replying after consultation with Jones. This story would be most incomplete if I did not add that as time showed that the California contentions about advertisements were correct, the editor and Jones again became friends and were such to the end. It must be remembered that in this campaign Jones, actually single-handed and in a new journal with no established prestige, changed the advertising policy of every decent medical journal in the country; a great feat, for it cost many journals thousands of dollars to give up the profits of their reprehensible

contracts, and cull their advertisers as they did their contributors. . . .

"And then comes, in the December JOURNAL, his wish expressed to us for a Merry Christmas and a Happy New Year—and the jubilation that we are all alive, when he, dear man, is not—so that the wish—his last for us—comes to us, literally, from his grave, and we can all be most certain that, wherever the consciousness which we knew as Phil. Jones may exist, that wish is just as keen and living as it was on the day he wrote it for us to read it in this December."

* * *

California Medicine, scientific and organized, owes much to the late Dr. Philip Mills Jones* and the group of loyal officers and workers who, with him, laid the foundations for the California Medical Association of today, and Doctor Jones's "New-Year Prayer" of twenty-five years ago still applies with equal and even more force. CALIFORNIA AND WESTERN MEDICINE presents it in the hope that its warmth of feeling and breadth of outlook may be taken to heart, by each and all of us; for then, at the end of the year 1938, no matter what trials and tribulations may have come to us, we shall still remain stronger and better units in organized medicine.

WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION: ITS PUBLICATION, "CALIFORNIA MEDICAL AUXILIARY COURIER"

Woman's Auxiliary Department of "California and Western Medicine."—Each issue of CALIFORNIA AND WESTERN MEDICINE presents, as one of its departments, "The Woman's Auxiliary to the California Medical Association," and we hope that the reports therein submitted are read not only by members of the Auxiliary, but by the California Medical Association members as well. It has been most interesting to note during the last several years, not only the steady growth of the Auxiliary through organization of new units, and consistent gains in membership in county auxiliaries already established, but also the record of increasing scope of work and influence.

* * *

Active Medical Practice Makes for Certain Limitations.—Let us be frank with ourselves. The responsibility of administrative endeavor in medical societies necessarily falls on the shoulders of a few members, the tendency being to let the physicians so elected or appointed bear the brunt of solving the problems so constantly coming to the front. In days gone by, with less social unrest than at present, the demands upon county medical society officers were not over-great, being limited at times to little more than preparation of programs for a certain number of scientific meetings to be held throughout the year. That condition, however, no longer obtains. Out of the air, almost, now come constantly new propositions to be faced, put forward sometimes, by well-meaning but poorly visioned organizations, but at other times, not infrequently, advanced by groups ill-intentioned from the outset toward the standards and advancement of scientific medicine and the public health. In short, the old order has changed, and it needs no deep study to convince an observing person that present-day menaces to scientific medicine will only be successfully overcome provided all members of the medical profession, as represented in organized medicine, and with the support of friends, will stand shoulder to shoulder, and give battle to those who, under whatever flag, would destroy medical practice as it has come into being through an evolutionary trial and error process. Granted that among the plans of theorizing visionaries and propagandists there may be here and there somewhat of merit, it still remains true, and is common sense, that in order to incorporate changes to overcome certain deficiencies in medical practice, it is not necessary and would be reprehensible to attempt reforms by revolutionary procedures that, in the end, would do more harm to public health interests than the good they were intended to or might bring into being.

* * *

Present-Day Turmoil of Economic and Social Unrest.—In the unsettled state in which the Nation is now trying to solve some of its economic and social-welfare problems, the theorizing propagandists have precisely the conditions favorable to the dissemination of their mouthings. To appreciate this, one needs only to glance through the newspapers and read between the lines, and observe how different is the portrayal of current news events than was the case a few years ago. The "free and independent press" of the present hour—believe it or not—watches, with keen eye, the trend of popular opinion, and, in contrast to days gone by, speaks kindly of this, that, or the other endeavor, when, not so long ago, the same matters would have received almost caustic editorial and reportorial criticism and comment.

* * *

The Lesson to Be Taken to Heart.—What is the lesson in all this, and what has it to do with the Woman's Auxiliary to the California Medical Association? Just this: Scientific and Organized Medicine need today every bit of their strength to successfully cope with the antagonistic influences directed against public health and medical practice. Most physicians, in the daily practice of their profession, have little time to sit in at service and other clubs where antimedical propagandists hold forth. Since, however, practically one-half of all clubs are women's organizations, it is understandable how representatives of the Woman's Auxiliaries to the California Medical Association, whose members take an active interest in the work of their literary, service and other clubs, can render most important aid in guiding aright, on public health and medical practice needs, the policies of such organizations.

* * *

State and County Auxiliaries in California Are on the Alert.—A perusal of the activities of the California county society auxiliaries, as given in each issue of the OFFICIAL JOURNAL, convinces one that the wives and daughters of California physicians are becoming increasingly

* For biographical data from *Journal A. M. A.* of December 2, 1916, see page 60 in this issue of CALIFORNIA AND WESTERN MEDICINE.

responsive of their own responsibilities in these matters. And it may be said, to their credit, that they are more than meeting their obligations. Wherefore, we welcome the messages brought to us in their semiannual publication, the *California Medical Auxiliary Courier,* and express the hope that, at some day not too far distant, the State Auxiliary will present to the California Medical Association Council for consideration, ample copy for a Supplement to CALIFORNIA AND WESTERN MEDICINE, in order that every member of the California Medical Association may note for himself what the gentler members of physicians' families are doing to promote the conservation of the public health and the advancement of medical science. If the California Auxiliary will continue to work in the future with the splendid discretion it has exhibited in the past, there must come to us all the wish that in due time—and not too far away—every county medical society of the California Medical Association will have associated with it a component county unit of the Woman's Auxiliary to the California Medical Association. Speed the day!

THIS AND THAT

Congratulations to Dr. Joseph P. Widney, Founder of the Los Angeles County Medical Association, on Attaining His Ninety-sixth Birthday.—December 26, 1937, was the ninety-sixth birthday of Joseph P. Widney,* M.D., D.D., LL.D., founder of the Los Angeles County Medical Association; founder also of the College of Medicine of the University of Southern California; co-founder of the *Southern California Practitioner;* ex-president of the University of Southern California, where, in the panic of 1893, as president, he pledged his personal resources to prevent foreclosures on the University's property; oldest living graduate of the University of California (Toland Medical College, 1866); an exemplar of the highest type of citizenship as manifested through years of consistent service; and a writer and author of half a dozen notable volumes, who only a few months ago, at the age of 95, brought off the press his latest book, "Civilizations and Their Diseases, and Rebuilding a Wrecked World Civilization."†

The career of Doctor Widney, who was born on December 26, 1841, has indeed been most remarkable, standing out as it does among his medical colleagues and fellow citizens like a beacon light to be seen afar by all who would chart their lives along lines of service and achievement. A bronze bust of the founder graces the rostrum of the auditorium of the Los Angeles County Medical Association headquarters building, there to remind members of that large component county unit how splendidly a life may be devoted to the service of mankind, both for todays of the present and the tomorrows of the future.

We extend to Doctor Widney, therefore, on behalf of the 5,700 members of the California Medical Association, our best wishes for the good health and happiness he has so richly earned, and urge a perusal of his latest book, from which some paragraphs are given below, for sober reflection upon the code which he long ago mapped out for himself as his own guide in his life work:

"I have never written for money. The sole object has been the carving out of broader lines for the human race. For more than fifty years of careful historical study, I have thought, and planned, and worked to this end. This ultimate purpose has run through all my publications. I have not placed upon the public market the books which I have written. I had not the time for this in an overworked life, nor have I had the means. My works have been placed, instead, in the great public reading rooms, and libraries, and colleges and universities of the world, where they might find the largest number of readers. This has drained heavily upon my private resources, so much so that I must still go on in the same old way. It is my contribution to the uplift of humanity and the making of a better world, and with this I am content.

"I am near to the beginning of my ninety-seventh year. Owing to injuries received in an accident, I have had to do all my work under the heavy handicap of being crippled, and in blindness, and in pain. Every word that I have published, for many years, I have had to dictate. What this means in patience, in difficulty, in labor, only one who has gone through it can know.

"There is still much that I have planned. Following the book now in the press ("Civilizations and Their Diseases, and Rebuilding a Wrecked Civilization"), there must come as a separate volume the work on the future of the Engle Man ("The Future of the English-Speaking Peoples"), to which I have made reference; thereafter, a book on "Life and Its Problems as Seen by a Blind Man at Ninety- —?—" In addition, there is other work which I need not enumerate. I had planned for a century; but this is in the Hands of One to Whom the centuries are only as a work-day. His will be done.

"Domine ad Te oculos cæcos levabo!"

* * *

Professor A. W. Meyer's Article.—In CALIFORNIA AND WESTERN MEDICINE for December appeared several articles concerning which comment may be made.

In the original article section, space was given to the scholarly discussion entitled "Use Destruction in the Human Body," contributed by A. W. Meyer, M.D., professor of anatomy at Stanford University. The facts therein outlined, based as they are on extensive and careful observations covering many years, and which are called, in conservative and scientific manner, to the attention of members, will have appeal not only to readers of CALIFORNIA AND WESTERN MEDICINE, but also to students of the subject, both at home and abroad. The contribution is a welcome addition to the literature.

* * *

District of Columbia and "Liberal Press" Articles.—In each issue of the OFFICIAL JOURNAL is a department given over to Special Articles,

* For biographical and other references concerning Dr. Joseph P. Widney, see CALIFORNIA AND WESTERN MEDICINE, April and May, 1936, pages 292 and 396.

† Review of this volume in CALIFORNIA AND WESTERN MEDICINE for December, 1937, on page 367.

Other volumes by Doctor Widney include:

Race Life of the Aryan Peoples, in two volumes. Pp. 698. New York: Funk & Wagnalls Company, 1907.

The Lure and the Land. Pp. 190. Los Angeles: Pacific Publishing Company, 1932.

The Genesis and Evolution of Islam and Judaeo Christianity. Pp. 238. Los Angeles: Pacific Publishing Company, 1932.

The Faith That Has Come to Me. Pp. 269. Los Angeles: Pacific Publishing Company, 1932.

Whither Away? Pp. 152. Los Angeles: Pacific Publishing Company, 1934.

The Three Americas. Pp. 306. Los Angeles: Pacific Publishing Company, 1935.

made up usually of a mélange of current-interest topics of such nature that physicians who desire to keep in touch with the trends in scientific medicine, disease features pertinent to California, or social welfare endeavors related to medical practice may find in their reading something worth while.

On page 433 of the December issue, for example, appeared an article, "United States Experiment in State Medicine Brings Protests," in which the story of what an agency of the Federal Government, the "Home Owners Loan Corporation—HOLC," is doing with public funds, by subsidizing, to the amount of twenty thousand dollars yearly, a coöperative clinic of federal employees. The HOLC maintains that it can thus use public funds to aid what in one sense is a private enterprise, because Congress, in order to permit the Home Owners Loan Corporation to do its major work, gave to that agency the status of a private corporation, vesting in its Board the legal rights of private corporations. It is stated that the District of Columbia Medical Association will take that issue into the courts, in order to have judicial opinion on whether public monies can be so used. The HOLC experiment is little other than an expression of state medicine, even though at the present time only two thousand employees are involved; and with comparatively little economic significance, perhaps, except as to principles involved. However, if the precedent so established were to be adopted by the many other federal agencies in Washington, D. C., with their thousands and thousands of employees, the matter would take on aspects of grave nature, not only to members of the medical profession at large, but to the entire tax-paying public of these United States.*

* * *

The "Liberal Press"—Excerpts from "The Nation" and "The American Mercury."—Readers who refer to the District of Columbia article may also be interested to peruse, on its opposite page, the item, "Two Articles of Interest in *The Nation* and *The American Mercury*," in which quotations from those publications are given; *The Nation* excerpt being a good example of the bias which exists in publications of its type toward the American Medical Association, and its constituent state organizations and their component county units. It was a fortunate coincidence that *The American Mercury* of the same month contained a critical analysis of the publication, *The Nation*, and it may be in order to reprint here the last paragraph of the December excerpts, to call attention to opinions expressed by the contributor to *The American Mercury*, in which he emphasizes the menace to American standards and traditions inherent in the outpourings of certain "liberal publications." Whether we agree or disagree with the thoughts so expressed, the quotations as given in the December issue (on page 432) are still worth the time of perusal:

"Furthermore, it is probably accurate to say that, today, the *New Republic* and *The Nation* are the most effective amateur propaganda adjuncts to the American Communist movement. For the once liberal weeklies are, in a sense, the bridge between Communism and the unconvinced intelligentsia. Their 75,000 subscribers, by a process of natural selection, are vocational molders of national opinion. They are teachers, writers, clergymen, professional men and women, social workers—the picked middlemen of American intellectual life." . . .

* * *

"Public Health Liability Act—Proposed Initiative 29."—This is a proposed law known as Initiative 29, which suddenly came to the front when efforts were made to have the Public Health Committee of the Los Angeles Chamber of Commerce grant its approval to the measure. At this writing, we are still in the dark concerning its sponsors, both direct and indirect. However, who may or may not be the authors and promoters of the proposed law, for the enactment of which its sponsors are making an effort to have it placed, as an initiative measure, on state election ballots of 1938, is, in one sense, of minor concern at the moment. It is the viciousness and absurdity of the provisions contained in the proposed law that warrant its careful perusal by every licensed physician of California, and it is therefore printed in full, with some italicized phrases by the Editor, on page 66, in this issue of the OFFICIAL JOURNAL.

The proposed law, among other things, would make an error of judgment in diagnosis a crime; would destroy existing standards of healing-art practice; would make physicians guarantors of cures; would make patients' records public documents; would make hospitals (including charitable hospitals) and their nurses liable for the acts of physicians using such hospitals; and would define major surgery, minor surgery, practice of medicine, wrong diagnosis, and unnecessary major surgical operation in a manner which would effectively prohibit medical practice as it is now understood!

Members of the California Medical Association are requested to read this proposed initiative law and satisfy themselves concerning the nature of this stupid measure, which, in the interests of the public health and of scientific medicine, must be opposed wherever it may be presented for consideration.

The attention of the officers of the California Medical Association has been called to this most recent attack upon legitimate healing art practice. In the meantime, members of the California Medical Association are requested to be on the alert, and to forward any additional information to the central office of the California Medical Association.

Other State Association and Component County Society News.—Additional news concerning the activities and work of the California Medical Association and its component county medical societies is printed in this issue, commencing on page 39.

* Note.—As the page proofs are about to go forward to the printer, we received a copy of a dispatch stating that the Acting United States Comptroller General had ruled the HOLC was without authority to loan $37,357.65 to the Group Health Association, Inc., of the District of Columbia.

EDITORIAL COMMENT†

EXPERIMENTAL RENAL HYPERTENSION

About ten years ago it was suggested by Farr[1] that the hypertension of Bright's disease is caused by renal ischemia secondary to nephrosclerosis. Doctor Goldblatt[2] and his coworkers of the Institute of Pathology, Western Reserve University, Cleveland, have devised an ingenious method to test this hypothesis, experimental renal ischemia caused by adjustable silver clamps placed about the main renal artery. The operation is performed retroperitoneally, with special instruments for the insertion and closing of the adjustable clamps. By this technique a "moderate" (30 per cent), "severe" (60 per cent), or "very severe" (90 per cent) reduction in renal circulation can be produced in experimental animals and maintained for several months or years.

Dogs, in which a "very severe" renal ischemia is so produced, show a rapid increase in systolic blood pressure, such pressure eventually reaching about twice the normal level. These animals soon show signs of renal insufficiency; urea nitrogen, nonprotein nitrogen and creatinin being increased in the blood stream. All animals with "very severe" ischemic kidneys die in about three weeks with typical manifestations of uremic intoxication.

Dogs, in which only "moderate" or "severe" bilateral renal ischemia is produced by this technique, usually survive the operation. Within from four to eight weeks a 100 per cent elevation in systolic blood pressure is usually noted, persisting with but slight change for at least fifteen months. Control experimental ischemias in other organs or parts of the body produced no significant hypertension in dogs. In the chronic renal hypertension the only subnormal renal function is a decreased "urea clearance"; blood urea, nonprotein nitrogen and creatin remaining within normal limits. The hypertension in these animals resembled that associated with so-called "benign nephrosclerosis" in man.

Two plausible explanations of the mechanism of renal hypertension were suggested by their findings: (1) a neurological theory, the assumption that afferent impulses from the nerve endings in the ischemic kidney to the sympathetic ganglia or vasomotor center might result in a general vasoconstriction and consequent elevation of systemic blood pressure; and (2) a hormonal theory, the assumption that the ischemic kidney gives off an unknown internal secretion, which by central or peripheral action causes a general vasoconstriction.

The neurogenic theory suggests that bilateral sympathectomy would prevent or cure renal hypertension. To test this conclusion, Doctor Goldblatt[3] and his coworkers excised the entire thoracic portion of the splanchnic nerves and the lower four dorsal sympathetic ganglion in four normal dogs, both sides being extirpated at the same operation. After full convalescence, renal ischemia was produced in these four dogs by their routine silver-clamp technique. In all animals typical hypertension developed in from four to eight weeks, and persisted for at least nine months, the animals being alive at the time of their report.

In a second group of dogs, renal hypertension had been produced from three to four years previously. Excision of the splanchnic nerves and lower four dorsal sympathetic ganglia caused no significant reduction in the renal hypertension in these animals. The authors conclude that "in dogs, excision of the thoracic portion of the splanchnic nerves and the lower four dorsal sympathetic ganglia, on both sides, does not prevent, cure or permanently lower in any degree experimental renal hypertension produced by renal ischemia."

To test the probable application of their results to human medicine, the Cleveland investigators[4] then attempted to produce a similar chronic hypertension in monkeys. Large, mature, young giant-type macaques were used. Blood pressure before and after the production of renal ischemia was determined by the Riva-Rocci method, the cuff being placed about the abdomen with auscultation of the femoral artery. An occasional control reading was made by inserting a hypodermic needle in the femoral artery and recording the "mean pressure" on a mercury manometer. In their most successful experiments both the systolic and diastolic blood pressure rose from the time of partial closing the second renal clamp. Maximum hypertension was reached by the end of about eight months, and has persisted till the time of their report (fifteen months). At the present time one monkey has a systolic pressure of over 300 millimeters of mercury, its preoperative pressure being in the neighborhood of 130 millimeters of mercury. The diastolic pressure in this animal had increased from the preoperative level of 90 millimeters of mercury to the present level of about 220 millimeters of mercury. The possible therapeutic effect of bilateral sympathectomy has not yet been tested in monkeys.

P. O. Box 51.

W. H. MANWARING,
Stanford University.

CARDIAC SYNCOPE AND SUDDEN DEATH

Acute cardiac syncope remains one of the most difficult emergencies with which the physician has to deal. The difficulty lies in the fact that the situation appears so suddenly, and that it may be either acute block or ventricular fibrillation. It is not easy to tell promptly which condition is present. Since effective treatment depends on the diagnosis, great

† This department of CALIFORNIA AND WESTERN MEDICINE presents editorial comments by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to all members of the California Medical Association to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

1 Farr, T., Handbch. spez. path., Anat. u. Hist., Berlin, 6:438, 1925.

2 Goldblatt, H., Lynch, J., Hanzal, R. F., and Summerville, W. W.: J. Exp. Med., 59:347, 1934.

3 Goldblatt, H., Gross, J., and Hanzal, R. F.: J. Exp. Med., 65:233 (Feb.), 1937.

4 Goldblatt, H. J.: J. Exp. Med., 65:671 (May), 1937.

skill is demanded in order to make a rapid decision and to act efficiently and wisely. California workers have made notable contributions in regard to the successful handling of either acute heart-block or ventricular fibrillation. Nathanson[1] of Los Angeles has made an especially clear analysis of the problem, and his work deserves full appreciation.

First carefully investigated by the English chloroform commissions, acute cardiac stoppage in anesthesia was shown in the classic studies of Goodman Levy[2] to be due chiefly to hyperactivity of the sympathetic system, with perhaps sudden adrenin release. In this situation ventricular fibrillation may occur. The clinical significance of this matter in anesthesia has been admirably discussed by Knoefel[3] and Guedel.[4] Knoefel makes the pertinent suggestion of using the barbitals in preanesthetic medication in order to prevent this type of syncope from developing. In an investigation particularly thorough, Nathanson has demonstrated that quinidin or acetyl-beta-methylcholin will prevent prefibrillation rhythm. Escamilla[5] has reported clinically on the use of quinidin in preventing transient ventricular fibrillation. The California group, therefore, emphasizes the importance of taking measures preoperatively to prevent ventricular rhythm from making its embarrassing appearance. This emphasis is certainly warranted, since effective treatment is difficult because of the acuteness of the situation once it develops. Certainly the etiology of ventricular fibrillation makes it clear that intracardiac injections of epinephrin are definitely contraindicated. Sensational newspaper reports of "bringing the patient back from the grave by injecting adrenalin into the heart" should decidedly not encourage surgeons to make intracardiac injections of epinephrin as soon as it may seem that the heart has stopped during an operation.

On the other hand, acute cardiac syncope may be complete heart-block resulting from excessive parasympathetic activity, either reflexly, as from pressure on the carotid sinus, or by central excitement and apprehension. In this situation atropin is well established as a method of paralyzing the vagal endings and preventing the acute block. The preoperative administration of atropin is definitely indicated for this purpose, especially in an apprehensive intellectual patient, who may give the impression of complete control of himself. This use of atropin is indicated in addition to its administration for preventing excessive flow of mucus. If acute heart-block does appear, Nathanson[4] has clearly shown that injection of epinephrin or its derivatives is the most effective means of getting the ventricles to beat again. These agents directly stimulate the cardiac accelerator mechanisms. It should be carefully remembered, however, that the very reasons for effectiveness of epinephrin in heart-block are the same for which it is contraindicated in ventricular fibrillation. If the heart stops in the early stages of anesthesia from vagal block, then intracardiac injections of epinephrin are justified, but if it goes into syncope from ventricular fibrillation, then epinephrin is contraindicated. How is the surgeon or anesthetist to tell promptly what the situation is? It is not easy, and for this reason it is wise to take proper preoperative measures to prevent either.

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THE UNPADDED PLASTER OF PARIS CAST

The use of plaster of paris or gypsum for splintage dates to the Arabian physicians[1] of the tenth century. Needed facility in handling of this plaster started a century ago when Mathijssen,[1] a Dutch army surgeon, promulgated the idea of impregnating cloth with dry plaster. In recent years the introduction of the fast-setting plaster has proved a tremendous advance. Originally, the gypsum casts were in massive blocks, but they have been evolved to the thinnest and lightest of all forms in the unpadded plaster type. The Austrian surgeon, Bohler, through his teachings has perhaps done most to promote this latter idea of splintage.

Those who are averse to plaster casts are apt to be doubly averse to the nonpadded type. A fracture axiom is this: "It is the doctor behind the splint, and not the splint that counts."[2] But given the use of proper details in the application of the unpadded splint, its wide field of application and its mechanical correctness should encourage enthusiastic adoption.

Air cushions are comfortable because pressure is distributed equally over wide surface, which makes pressure per unit area very small. A pillow of feathers is soft to the head for the same reason. If it were possible to make out of stone a perfectly fitting cast to the head, this "stone pillow, theoretically, should be quite as soft as feathers. A version of Pascal's simple physical law of the transmission of pressure is expressed in the statement that total force is equal to the product of pressure or weight and area. ($F = P \times A$). The principle finds a common illustration in the hydraulic press. With a given force, pressure will increase as the area decreases, and conversely pressure will decrease as the area increases. A well-fitted, unpadded plaster cast creates a maximum area with a resultant minimum pressure. Ill-fitting casts, padded casts, and the mechanical devices which offer support in re-

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stricted surfaces, provide a limited area, creating thereby greatly increased pressure.

Early reduction of a fracture with application of an unpadded plaster cast completely surrounding the part will in many cases prevent swelling that would otherwise occur. Swelling that may occur following application of the cast usually is controllable by elevation of the part. At the outset the cases require watching to prevent and intervene if necessary, should signs of potential serious ischemia appear. A nonpadded plaster cast maintains fixation which cannot be promised in the padded type. In this latter splint it is practically impossible for padding to be uniform, and encircling bandages over the padding usually accentuate the lack of uniformity. An unpadded plaster of paris collar in the case of a cervical spine fracture, fitted carefully and extending down beneath the arms and over the upper chest, offers a "maximum area with a resultant minimal pressure." This type of splint is far more comfortable than the leather collars and other apparatus whose sole support focuses on a few square inches and thereby magnifies the local pressure. Padded casts for other parts of the spine or the extremities soon become loose, and the ill-fitting points of contact support the total pressure which becomes greatly amplified, but which would be minimal were surface available to dispose pressure widely and evenly. Poking cotton and packing beneath casts about pressure spots rarely is of value; on the contrary, very soon it creates a new pressure point or irritates an old one when the padding rolls into a wad and becomes displaced. The packing interrupts wide surface contact and multiplies pressure through diminishing contact area.

Success with the unpadded plaster cast depends on close attention to details in its application. When practicable, swelling should be dispersed before these casts are applied. When not practicable, old casts should be replaced by new ones when swelling has subsided. In applying the plaster, bandages should not be drawn tightly but lightly. Creases should be avoided. The plaster should be modeled; in doing this, pressure is not made with the finger tips but with the whole surface of the hand and with a force that disposes the plaster evenly. Fast-setting plaster is particularly desirable for successful modeling. Cut patterns of plaster for any part will often greatly aid in the ease and perfection of application. The patterns may be reenforced or united in their segments by the circular bandage of plaster. Modeling the plaster over potential pressure areas, such as the malleoli, the heel, the neck, the spine and joints generally, will meet with more success if small squares or units of plaster are used. Two by two inches represents a suitable size for many purposes. The smaller the part to be modeled, the smaller the square or strip of plaster should be that is used, if smoothness and evenness of application are to be achieved. Even such small parts as fingers may be splinted with unpadded plaster either for splintage itself or for purposes of traction. A case in point is a badly compounded fracture of the metacarpals with the whole hand considerably infected. Hazard of infection precludes skeletal transfixion through the phalanges. Small strips of plaster, one-half inch in width, would make in this case perfect nonpadded casts to the fingers that would be comfortable. Hooks for traction can be incorporated in the plaster. After drying, the plaster may be shellacked, the part set up in a banjo-splint, and wet dressings and irrigating solutions would prove to be practicable.

In summary it may be said that the unpadded plaster casts are comfortable because the wide surface of contact brings unit pressure to a minimum. Their use early in fractures following reduction minimizes swelling. These splints insure unchanging fixation and allow a patient quickly to become ambulatory. The combination of their beneficial qualities hastens bony repair and rehabilitation. They are not difficult to apply; they may be made light in weight and thin, and are economical. Success in their use, however, demands close attention to details in their application. Wide field of application, finish and, above all, mechanical correctness, will insure, it would seem, increasing adoption of the unpadded plaster of paris cast.

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LOCAL INJECTION ANESTHESIA: SOME ERRORS IN CONNECTION WITH ITS USE

A recent sequel to the injection of novocain and adrenalin leads to the presentation of the following unfortunate developments in connection with the use of novocain anesthesia locally.

In the above incident a man of seventy, definitely arteriosclerotic but without any evident peripheral vascular insufficiency, had the base of his right index finger injected with about 10 cubic centimeters of one per cent novocain, containing several drops of 1:1000 adrenalin. A tourniquet was not used. Incision was made for the cure of a paronychia. Three hours later the finger was cold and cyanotic, and the condition went on to a definite gangrene.

A woman of forty-five came to the out-patient department of a large county hospital, for the removal of a lipoma from the popliteal region. The tumor had been present for many years. The soft growth was the size of a fist, rather fixed, and seemed to infiltrate the underlying tissue. The overlying skin was prepared with iodin and alcohol, and a sterile towel placed near the field. Sterile gloves, but only a "clean" gown was used by the operator. A considerable quantity of one per cent novocain without adrenalin was infiltrated in and about the tumor, and an incision was made over the growth. Some difficulty was encountered in its removal, as it seemed to extend toward the knee joint in a branching fashion. A great deal of bleeding was present, and the assistance necessary for the proper exposure of the wound was not available. Finally, the tumor was removed; a Penrose drain inserted, and the wound sutured. On the patient's return two days later, the wound was

found infected. She was hospitalized, and most of the sutures removed. A definite cellulitis, however, had set in, and multiple incisions of the leg were found necessary. The infection did not clear up, but invaded the knee joint. After several months of drainage and disability, the leg had to be amputated above the knee.

A man of twenty-two had some vague complaints referable to the abdomen and an irregular, low-grade fever. The diagnosis was obscure. A palpable node was found in the left axilla, and it was decided to remove it for biopsy. The skin was prepared with iodin and alcohol, and the tissues infiltrated with one per cent novocain. A two-centimeter incision was made over the node. However, the gland proved to be elusive and was not easily found. An excessive amount of fat called for considerable dissection and more novocain. Finally, a bit of tissue believed to be the node was removed, and the wound closed without drainage. Two days later there was redness and tenderness at the site of the incision. A cellulitis developed and repeated incisions were made. Drainage continued for many months, and the end-result was a weak, atrophic left arm with a stiff shoulder.

From the above incidents it would appear that a more critical selection of cases for local novocain anesthesia should be made, and that:

1. In the aged, on extremities, adrenalin should not be used with novocain.

2. Minor surgery under local anesthesia should be treated with the same aseptic respect as major surgery, provision being made for adequate draping, assistance, and control of bleeding.

3. Either general or regional block, rather than infiltration anesthesia, is preferable where excess fatty tissue is present, or extensive dissection is done.

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ON THE FATE OF EPINEPHRIN IN THE BODY

Pharmacologists have long known that the effects of epinephrin, injected into the animal body, are quite transient—a fact which limits its therapeutic use.[1] Just what happens to epinephrin in the animal body is not known. The hormone is readily autoxidisable *in vitro* under the conditions of pH and temperature which obtain in the body, and it has often been assumed that the same mechanism is responsible for the inactivation occurring in the body. The recent investigations of Blaschko and coworkers[2] indicate that the *in vivo* inactivation of epinephrin is indeed due to oxidation, but that such oxidation differs in important respects from the course of events *in vitro*.

As a background for consideration of the inactivation of epinephrin in the body, the facts known concerning *in vitro* oxidation will be briefly outlined. The first oxidation product appears to be an orthoquinone. On further oxidation an indole derivative is produced, which is probably responsible for the pink color appearing in epinephrin solutions on standing. Complex oxidation and polymerization follow, some eight or nine atoms of oxygen being absorbed for each molecule of epinephrin present. Sympatheticomimetic activity is probably lost with the first step in oxidation.[3]

It is unlikely that autoxidation is the sole cause of inactivation of epinephrin in the body, since various substances present in blood and other body fluids and in tissue extracts serve to delay this reaction markedly. It is now known that amino-acids, guanidine, ascorbic acid (vitamin C), cystein, glutathione, and possibly other substances serve to inhibit the autoxidation of epinephrin. The rate of disappearance of epinephrin differs in different tissues—a fact which necessitates qualification of Elliott's statement that "adrenalin disappears in the tissues which it excites."[4] For example, no disappearance of the hormone occurred on perfusing blood containing epinephrin through the hind legs or lungs. The chief site of inactivation appears to be in the liver, kidney, and small intestine. Blaschko and coworkers[2] have shown that an enzyme system is present in these tissues which brings about rapid oxidation of epinephrin. This enzyme they have named "adrenalin oxidase." In accordance with earlier work, this enzyme was shown to be absent or present in very low concentration in skeletal muscle or spleen. There is no known reason why this enzyme system should not be operative *in vivo*. It is certainly suggestive that the organs in which it has been found are those which the earlier workers discovered were chiefly responsible for the disappearance of the hormone from the circulating blood.

The oxidation of epinephrin *in vivo* differs from that *in vitro*, not only because of the presence of this enzyme system in certain tissues, and because of the widespread occurrence of inhibitors of autoxidation, particularly sulphydryl compounds, but also in the fact that the total oxygen uptake *in vitro* is seven to eight molecules of oxygen per molecule of epinephrin, whereas the total oxygen uptake *in vivo* is but four atoms per molecule. This implies a quite different chemical picture.

Summarizing: The transient effects of epinephrin in the animal body are probably attributable to oxidation of the hormone through the action of "adrenalin oxidase." This event occurs chiefly in the liver, kidney, and small intestine.

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Success, in so far as it may be gained through training, is won by cultivating such powers and attitudes of mind as interests; the habit of observing and reading; expressing one's self through conversation and discussion, through speaking and writing; intellectual curiosity and study; freedom from superstition and prejudice; open-mindedness; and the ability to profit by experience.

ORIGINAL ARTICLES

MICRO-SURGERY IN CHRONIC SIMPLE GLAUCOMA*

By Otto Barkan, M.D.
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Discussion *by Robert Steele Irvine, M. D., San Francisco; Joseph Crawford, M. D., San Francisco; John C. Williams, M. D., San Francisco.*

THE writer has recently reported an operative procedure[1,2] for the relief of chronic simple glaucoma, which consists of opening Schlemm's canal under direct magnified vision. This procedure removes the block to the circulation of intra-ocular fluid which can be shown to be the mechanical cause of the increased intra-ocular pressure. It restores the physiological direction of outflow to the intra-ocular fluid instead of creating an abnormal outlet with its frequent complications and sequelae that may follow present-day operations. By means of a contact glass which has been devised for this special surgical purpose, the operator can see the area of blockage, and can watch and guide his instrument during the operation. The operative procedure when thus performed is without danger, and its objective, namely, opening of Schlemm's canal, can be deliberately performed with the trabeculum under full view. In those cases in which the trabeculum was incised over a sufficient extent, the intra-ocular pressure has returned to normal. According to observations during the last one and a half years, the results show promise of being permanent.

In this article an improvement of technique is suggested which will more certainly insure the opening of the canal. The original technique of operating under 4 x magnification affords a convenient range of some 20 centimeters and a fairly wide field. Because of the moderate degree of magnification, however, one cannot be quite certain of always striking the canal and of opening it over a sufficient extent in all cases. In those cases in which the canal was insufficiently opened, the intra-ocular pressure has been only partially reduced, and a later operation has been necessary to secure normal pressure. The technical variation suggested in this article consists of increasing the magnification from 4 x to 20 x. This increase of magnification is obtained by using the binocular corneal microscope attached to the surgeon's head by means of a helmet (Fig. 1). Although not easy of performance, the assurance of opening Schlemm's canal afforded by this higher degree of magnification would seem to be an improvement over the original technique in those cases where it is indicated.

MICRO-SURGICAL TECHNIQUE OF OPENING SCHLEMM'S CANAL UNDER DIRECT VISION

The surgeon wears a helmet to which is attached a binocular corneal microscope. He helps to steady the microscope with his left hand which, in turn, by means of a finger, keeps in contact with the patient's head. A trained assistant standing behind the patient's head for the left eye, and at his right side below the head for the right eye, fixates the bulbus at the temporal limbus with a small Elschnig forceps held in his right hand. With his left hand he steadies the surgical contact glass by means of a double-pronged probe which fits into two depressions on the convex surface of the glass. A second assistant guides the narrow beam of the hand lamp from across the bridge of the patient's nose to transilluminate the nasal portion of the limbus and the corresponding region of the angle of the anterior chamber. The surgeon supports and focuses the microscope with his left hand, while he guides the knife with his right hand. He sits on a stool adjusted to such a height that, by means of a slight movement of his head, his gaze may be directed first at the limbus and then transferred above the temporal edge of the contact glass to the anterior chamber, from which point he continues to guide the knife across the chamber by direct vision through the glass. When the blade reaches the highly magnified angle, its point is inserted exactly into that portion of the trabeculum which covers Schlemm's canal and the incision is continued for several millimeters along this line. That this may be accomplished with a high degree of certainty and exactitude is proved by postoperative biomicroscopic examination of the angle, which shows a single straight dehiscent slit of the trabeculum opening Schlemm's canal. What appears to be the glistening white inner lining of the opposite side of Schlemm's canal is clearly visible through this longitudinal bisection of its wall (the sclerocorneal trabeculum may be found to be bisected or sometimes torn off, constituting what may be called either a trabeculotomy or trabeculectomy, as the case may be). The working range is 6 centimeters

Fig. 1.—Photograph showing use of the binocular corneal microscope in author's operation of opening Schlemm's canal under direct vision.

* Read before the Eye, Ear, Nose and Throat Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

from the patient's eye to the tip of the objective, or 20 centimeters from the patient's eye to the eye of the surgeon. The image is kept in focus by the surgeon shifting his head, and for finer adjustment by using the sliding scale of the microscope, for which the fingers of the left steadying hand are used.

MICRO-GONIOSCOPE

The binocular corneal microscope has in the past been used by some ophthalmologists for the removal of foreign bodies from the cornea. This procedure I have found satisfactory in routine practice for many years, the patient sitting upright with his head on the chin rest. Recently, Schoenberg [3] has suggested its use for intra-ocular surgery, and reports attaching the head of the corneal microscope to a stand on a table, at the side of which the patient is lying, in order that it may be used in the course of surgical operations. He suggests that various uses are possible, but does not, as far as I can gather from reading his article, report having actually applied it to intra-ocular surgery nor proved its practicability for this purpose. Before reading his article such a use had occurred to me for my "micro-gonioscope," [2] which consists of a binocular microscope mounted on a highly flexible stand; however, the semi-rigidity of even this very flexible apparatus renders it unsatisfactory for purposes of intra-ocular surgery. It was for this reason that I divorced the microscope head from its stand and attached it to the surgeon's head where, with the additional steadying influence of the surgeon's hand, which maintains contact with the patient's head, it works out satisfactorily. Contact with the patient's head is found to be necessary if one considers that the slightest movement between microscope and object is magnified 20 x, and if one further takes into account the narrow breadth of focus and the limited field of vision when using this high degree of magnification. The field of vision, when using the 2 x objective and 10 x ocular combination is only 6.9 millimeters in diameter.

CONCLUSION

Examination of the living eye with the binocular corneal microscope is customarily called "biomicroscopy"; examination of wet specimens of the eye with the same instrument has been termed "micro-anatomy." [4] To operate within the living eye with this technique may be aptly termed intra-ocular "micro-surgery." As far as I am able to judge from a review of the literature, this is the first time that such high magnification has been applied in intra-ocular surgery.

The use of the binocular microscope, although it demands deliberate care and trained assistance, is feasible, and the procedure of choice when operating on Schlemm's canal under direct magnified vision in those occasional cases where extra assurance of striking the canal is required.

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DISCUSSION

ROBERT STEELE IRVINE, M. D. (490 Post Street, San Francisco).—That the results of the present treatment of chronic glaucoma are far from satisfactory can scarcely be disputed by anyone who will take the trouble to review his own records, or those of any clinic, where a fairly large amount of material is available. We frequently see these patients with a gradual loss of vision, despite our efforts, until the familiar and tragic white cane appears on the scene.

This paper of Doctor Barkan's is the summation of what he has written and done within the past three or four years, and presupposes some knowledge of the foregoing. It is an application, in a greatly improved manner, of the surgery of De Vincentiis, controlled by visualization through a contact glass such as heretofore had been limited to diagnostic purposes only in the attempts by Trantas, Koeppe, Frick, and Troncoso. He has set up definite conditions for its application, which enable him and us to determine its possibilities.

I have had the privilege of examining with Dr. Otto Barkan several of these patients, both before and after this microsurgery, and with his equipment the demonstration is not difficult and is indeed striking. I have also seen the operation performed, have seen the records of patients, over a period of two years, and have been impressed by the freedom from operative trauma, and the consistency of the results, as to the reduction of tension. The pigmented trabecular line can readily be recognized and incised under direct, magnified vision. There is no loss of aqueous, with the resultant plasmoid fluid, to further unbalance the mechanism.

Most of us are accustomed to working under high magnification, such as removing foreign bodies with a corneal microscope or slit-lamp, but unless this dexterity is present it does require unusual coöperation by the assistants and some skill, to avoid damage to the iris or scleral spur, or perforate the cornea. This is the reason for visual control throughout the incision. The difference between the arc produced by the knife, and that of the limbus must be considered.

This paper stresses the latest development in higher magnification, which, up to the point of too much narrowing of field or distortion, insures greater accuracy in placing and controlling the incision; a new field of surgery for which we should be appreciative.

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JOSEPH CRAWFORD, M.D. (Medico-Dental Building, San Francisco).—Before discussing this modification of the author's operation for the relief of chronic simple glaucoma, by using a binocular corneal microscope attached to the surgeon's head, instead of an ordinary loupe, a brief description of the operation itself may be in order. If we accept the author's premise that the most frequent cause of chronic simple glaucoma is obstruction of the flow of aqueous from the anterior chamber into Schlemm's canal with a consequent rise of the intra-ocular pressure, any operation reëstablishing this function of that canal is indicated. Most of the operations used today for the relief of chronic simple glaucoma are external, filtering operations, in that they provide egress for the aqueous that is drained off imperfectly. De Vincentiis, in 1892, first suggested an internal incision in the iridic angle to reëstablish the normal route through Schlemm's canal; but due perhaps to the danger of the operation—for it was a blind one—it was not accepted generally. The danger is that of injury to the ciliary body, with resultant hemorrhage. Similarly other operations which are now also almost obsolete, such as anterior sclerotomy and internal sclerotomy of de Wecker, when they were effective in this type of case would appear

to have been so by virtue of their having struck the trabeculum on their way into the chamber. Otto Barkan first suggested the idea of incising Schlemm's canal from the inside while it is under direct binocular observation. He devised a contact glass which, when used with a loupe and a good source of focal illumination, makes it possible to incise the sclerocorneal trabeculum over Schlemm's canal while it is under full view. This type of internal filtering operation has much to recommend it, because it restores the physiological direction of outflow for the aqueous.

The magnification with a loupe is four times. Greater magnification is desirable. The binocular microscope increases the magnification to twenty times, but at the expense of working distance, breadth of field, and steadiness of image. Anyone who has tried removing a corneal foreign body under a slit-lamp can appreciate the difficulties of operating with these limitations. To perform such a delicate operation, as incising the sclerocorneal trabeculum with the microscope fastened to the surgeon's head, would make the operation too difficult for any but the most skilled operator.

While I have not as yet performed the operation, due to lack of a suitable contact glass, through the courtesy of Doctor Barkan I have had the opportunity of seeing a number of patients on whom he has operated. The results were so much better than one could expect from operations for the relief of chronic simple glaucoma that one cannot avoid being enthusiastic about its possibilities. Patients who had a persistently high tension with typical glaucoma fields before operation, had normal tensions for as long as a year after operation. The need for continued use of miotics had ceased. Amazingly enough, in one or two cases, there was an increase in the visual field. Most astounding of all was the fact that there was no visible evidence of an operation except by examination with the microgonioscope. The usual signs of a filtering operation, such as distorted iris, conjunctival scarring, bleb formation, etc., were lacking. Instead, an examination with the slit-lamp and contact glass revealed in the iris angle a long, gaping slit in the trabeculum, so well described by the author in previous articles. No one could see these postoperative results without the conviction that, at least in many cases of chronic simple glaucoma, surgical relief is possible and the operative problem is solved.

It appears to me that, for routine work, the operation is such an excellent and practical one that every eye surgeon will eventually use it in many, if not most of the cases of chronic simple glaucoma. By using the technique originally described by the author, the operation is feasible for anyone doing ophthalmic surgery.

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JOHN C. WILLIAMS, M.D. (490 Post Street, San Francisco).—The new method of approach of Dr. Otto Barkan to the study and alleviation of glaucoma has already given remarkable results and holds greater promise. As progress is made in the study of the micro-anatomy of the angle, refinements of technique will follow, and it is on this account that we view with such interest the application of high magnification not only to the study of the angle but, as we learn in this paper, also to the actual surgical procedure. On expressing my interest in his research, Doctor Barkan offered me the opportunity to study his methods and follow the results obtained. In two cases, I have followed the clinical course for a long period before the trabeculotomy, as well as afterward. Full control of the increased intra-ocular tension was never obtained under medical care, with the consequences that central and peripheral vision were gradually decreasing. After opening Schlemm's canal about one-fourth of its circuit, tension has been within normal limits without further use of miotics, and both central and the peripheral vision are improving. It is particularly fortunate in one of these cases that pilocarpin is no longer necessary, since the lids had become sensitized to its use. It may be said, in parenthesis, that miotics are used as a temporary measure after incision of the trabeculum to pull the root of the iris away from the angle until healing has taken place. This period of time is brief, for the after-reaction to this surgical procedure is remarkably slight. It would be feasible to repeat the operation if future time should show its necessity; but patients followed over a period of several months continue to maintain their improvement. In certain cases in which the glaucomatous process has not been fully controlled, it has been found that Schlemm's canal has not been adequately opened for a sufficient extent. Results of properly selected cases convince me that Dr. Otto Barkan's procedure in opening Schlemm's canal has proved a notable advance over existing methods in controlling chronic glaucoma. If the use of high magnification fulfills its promise of allowing this work to be done more accurately, it will be held a valuable addition to eye surgery.

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DOCTOR BARKAN (Closing).—I wish to thank the discussers for their contribution to the subject, and their words of appreciation. I have not yet seen any of these openings of Schlemm's canal close up. It is my impression that there is no tendency to heal over. However, the number of cases (twenty-five) operated on to date is too small, and the time elapsed too short to permit of any definite statement in this regard. In those instances where the incision has been insufficient and the result incomplete, it is possible to operate again. Operation is indicated in those cases which I have classified as Type I, and which are characterized by an open angle and a blocked trabeculum. There are also other cases, such as certain types of secondary glaucoma and hydrophthalmus, where the method is applicable. I am glad that the safety of the operation has been brought up, and that, in view of its being so safe, which cannot be said of any other glaucoma operation, one of its main applications may prove to be as an early operation. The operation can be performed by any well-trained and properly equipped ophthalmic surgeon. I expect that the latest model of the surgical contact glass, which was completed a few weeks ago, will prove to be the final one and should be available by you all within the next two months. I should like to take this occasion to suggest that anyone intending to do the operation should familiarize himself with the diagnostic set-up and with biomicroscopy of the angle of the anterior chamber before embarking upon the surgery of it.

PHYSICAL PHENOMENA ASSOCIATED WITH ANXIETY STATES: THE HYPERVENTILATION SYNDROME*

By WILLIAM J. KERR, M.D.
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DISCUSSION *by Edwin L. Bruck, M. D., San Francisco; Mayo H. Soley, M. D., San Francisco; Samuel D. Ingham, M. D., Los Angeles.*

IN the past several years, increasing emphasis has been placed upon the importance of the interaction of the physical body and the emotions. It is now realized that emotions may precipitate the symptoms of physical disease; and it is assumed that variations in the severity of a disease in a group of patients with the same illness can often be explained by variations in intensity of their emotional disturbances.

The most obvious instances of the interrelationship between emotions and disease have been found in the study of patients who have had secondary psychic manifestations which have necessitated consultation with a psychiatrist. However, there are less well-defined psychological disorders which underlie manifestations of disease; and these are

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less easily recognized. The internist is often called upon to make a diagnosis in cases where the patient's true illness is masked or simulated by symptoms which are the direct result of the emotional state of the patient. In some instances the symptoms imitate so closely those of a common illness that the disease is diagnosed erroneously, and a discouraging prognosis is given. This results in an obvious reaction on the patient. Already the subject of anxiety and burdened with emotions, he becomes overburdened by the added anxiety concerning his state of health.

A FUNDAMENTAL CONCEPT

To understand the reactions described above, it is necessary to accept a fundamental concept. The principle of psychobiology states that body and mind are indivisible, and that the body or physical structure without the mind is inanimate and has no human meaning. Whatever affects either the body or the mind at any time affects the individual as a whole.

Such a principle seems almost too obvious to be worth mentioning. However, it is stated at this time because too many physicians and surgeons, although recognizing its truth, continue to treat only the patient's body. When a patient's symptoms do not respond readily to treatment of organic disease, and evidence of anxiety is uppermost, the patient is classified as neurotic and is forthwith referred to another physician. However, more and more internists and surgeons are coming to recognize the importance of the relationship between mind and body; and, as a result, psychiatry is gradually losing its identity as a medical specialty and is, instead, becoming a new tool in the hands of internist and surgeon.

PSYCHOBIOLOGIC APPROACH

The psychobiologic approach, with its concept of the unity of the human organism, has served to widen the scope of psychiatric investigation. The immediate result of this more extensive investigation has been a deeper appreciation of the emotions of the individual. Comprehension of the importance of the emotions has been difficult because many physicians and surgeons have considered the indefinite symptoms, often complained of by patients, to be purely imaginary and without physiological basis. As a matter of fact, these indefinite symptoms have the same underlying mechanism as more physical manifestations, such as diarrhea and urinary frequency, which are not in any sense of the word "imaginary," and yet which may be caused entirely by disturbances of the emotions.

AUTHORS' STUDIES

During the past three years, several of us have been attracted to one phase of this problem because an increasing number of patients have appeared who were suffering from symptoms of tetany which could be explained only on the basis of hyperventilation. Also, patients have been seen in consultation who had definite symptoms and signs of organic disease, but who were suffering, in addition, from symptoms similar to those of patients who had been found to have hyperventilation tetany. Hyperventilation exercises and metabolic tests gave similar results for the patients in both groups, and all of them responded to the same type of therapy.

HYPERVENTILATION TEST

For the study of these patients, the hyperventilation exercise has been devised as a diagnostic procedure. In this test the patient is asked to lie on a bed without constriction from clothing, and to breathe at a rate of eighteen to twenty breaths per minute. Thus, hyperventilation is induced, which reduplicates or aggravates the patient's symptoms.

OTHER TESTS

In addition, the following tests were made on the patients of our series in order to rule out other causes of tetany, and to determine, if possible, whether or not a state of alkalosis existed: The reflexes were tested before, during and after the hyperventilation experiment. Before and after the exercise, determinations of the carbon dioxid combining power, chlorids, proteins (serum albumin and globulin), magnesium, calcium (diffusible and nondiffusible fractions) and phosphorus of the blood were made. The p^H and content of ammonium salts of the urine were estimated. In most instances, the basal metabolic rate was determined.

For all the patients in our series, similar results were obtained from these tests. The usual causes of tetany were eliminated. An alteration in the carbon dioxid combining power of the blood and a decrease of ammonium salts in the urine were found, which suggested that alkalosis was present. Since rather cumbersome methods were used at the time the studies were first made, it is possible that more marked changes had occurred followed by a partial return to normal before the samples were obtained. That such was the case is suggested by the results of later studies made by Doctors Shock and Soley,[1] who used a micromethod which is mechanically more adaptable. Their findings seem to indicate that the whole reaction is caused by tissue alkalosis, with the subsequent production of tetany or allied symptoms.

HYPERVENTILATION SYNDROME

Briefly, the train of events leading to the production of anxiety and the subsequent development of the hyperventilation syndrome can be described as follows: An individual has a difficulty to meet. The reaction, psychologically, may be one of two types: the individual may face his problem squarely and find a solution; or he may attempt to ignore the difficulty and to deny its existence. Regardless of any attempt on the part of the patient to deny the existence of his difficulty, nevertheless it still exists. In our opinion, it is the suppressed emotion associated with the difficulty that directly stimulates the autonomic nervous system. The sympathetic nervous mechanism is aroused, and the most outstanding reaction is a stimulation of secretion by the adrenals. The cerebral cortical centers are stimulated directly, and also by oversecretion of adrenalin. Adrenalin irritates also the cardiac and respiratory centers, causing at first a slow heart

rate with a large stroke-volume output, and later a rapid heart rate. There is speeding up of the respiratory rate and increase in ventilation. With the increase in ventilation the carbon dioxid in the alveolar spaces is expelled, and more is shifted from the blood stream and tissues into the alveolar spaces. Chlorids are retained in the blood, and phosphates likewise. Urea is not produced by the liver, hence ammonium salts are decreased in the urine. These later manifestations are the result of an attempt on the part of the body to prevent too great a shift to the alkaline side because of the sudden loss of carbon dioxid. However, the buffers that are mobilized do not entirely compensate for the loss of carbon dioxid, and as a result the patient suffers from the lack of sufficient acid ions and experiences irritability of muscle tissue because of alkalosis.

RÔLE OF ALKALOSIS

Some investigators[2] believe that the alkalosis does not explain the whole picture in this syndrome. They assume that the symptoms are caused by asphyxia, a lack of sufficient oxygen in the tissues. It has been stated that the attacks may be relieved by inhalation of oxygen without any carbon dioxid in the inspired gas. To a certain extent these conclusions may be true. Years ago[3] physiologists described the effect on the peripheral vascular bed of alkalies, oxygen, carbon dioxid, and acids; and of stimulation through the controlling centers in the central nervous system. It was found that acids and carbon dioxid, when applied locally, dilated the capillaries; when applied centrally, these vessels were constricted. In the study of patients suffering from the hyperventilation syndrome, both of these changes[4] in the peripheral vascular bed of the hands and feet have been found. Alternately, areas of cyanosis and redness caused by dilation of venules and arterioles, and areas of blanching due to arteriolar constriction, have been observed. These alterations in the condition of the vascular bed are sufficient to cause sensations in the skin through irritation of nerve-endings. Paresthesias have been described in nearly every instance.

SYMPTOMS OF HYPERVENTILATION SYNDROME

When the hyperventilation syndrome is present, a typical description of symptoms may be secured from the patient without much prompting. Some patients state that after a minor nervous reaction, epigastric discomfort is experienced, or palpitation followed by rapid heart rate. Sometimes there is a sense of constriction around the throat; and breathing deeply not only may fail to give relief, but may aggravate this symptom even to the point where the patient feels that he is suffocating. The patient, himself, or one of his relatives, may have noted that he is in the habit of sighing frequently, particularly when he is restless. Frequently the patient will be seen to gasp while describing his symptoms to the physician. Other symptoms that are often mentioned are stiffness of the hands and feet, dizziness, slight nausea, weakness and easy fatiguability. The sensations complained of are frequently described as severe or painful.

In many patients the hyperventilation exercise will reproduce all of the symptoms which have occurred during attacks. When carbon dioxid is inhaled from a small tank through a mask, with the patient continuing to breathe as during the exercise, these symptoms rapidly disappear.

Sometimes it is difficult for the patient to understand why small irritations now disturb him so much, whereas formerly considerable irritation was necessary to produce the marked sensations. The effect of adrenalin is that of increasing summation of nerve impulses; it has no effect on the chronaxie of the nerve. Because this is true, small or insignificant stimuli will in time cause protean manifestations. This is the reason why these symptoms can be induced in normal individuals by prolonged volitional breathing, although under ordinary conditions they do not have these sensations.

DIAGNOSIS

There are a number of common diseases, the symptoms of which are simulated by the hyperventilation syndrome. In an intensive study of thirty-five patients,* and observation of a larger group, a number of patients were found who had symptoms of precordial pain and rapid heart rate. Some of these patients were referred by physicians who had made the tentative diagnosis of coronary occlusive arterial disease or of aneurysm of the aorta or angina pectoris. When it was found that they reacted positively to the hyperventilation exercise, these patients were treated accordingly, and relief was obtained.

Other patients were seen who had suffered from symptoms suggesting Raynaud's syndrome. In these, spasm of the carpal arterioles was initiated by hyperventilation, and was relieved by the use of acid salts and an acid-ash diet.

There were several patients who had suffered asthma. In some of these an eosinophilia was noted. After all types of allergic reaction had been ruled out by skin tests and trials, the procedures described above were instituted, and successful therapy given.

Symptoms of peptic ulcer were found more often than those of any other disease. The Sippy treatment had aggravated the condition of these patients, for a very obvious reason. With the patient already bordering on a state of alkalosis, the addition of alkaline powders was more than enough to precipitate symptoms.

Other conditions with which this syndrome was confused were thyrotoxicosis and Mèniére's disease. Many of the patients with the former condition returned with recurring symptoms of thyrotoxicosis, following removal of an adequate portion of the gland. On examination, no objective findings indicated a return of thyrotoxicosis. These patients, likewise, responded to therapy directed toward the hyperventilation syndrome. In the group with Mèniére's disease, it was noted that nystagmus could be induced easily by the hyperventilation exercise; however, some one of the

*A detailed report of this study will appear in *The Annals of Internal Medicine.*

classical symptoms was usually lacking, *e. g.*, tinnitus, or loss of hearing. Ventilation with carbon dioxid immediately restored these patients to a normal condition.

It should be kept in mind that the danger of any unified diagnosis for several groups of symptoms lies in the use of such a diagnosis as a wastebasket for all uninteresting and obscure diagnostic problems. The value of an understanding of the hyperventilation syndrome is dependent upon the degree of diagnostic acumen of the physician. Failures and regrettable mistakes will be made if true organic disease is diagnosed as the hyperventilation syndrome. A case in point is that of a patient on our hospital service. This woman complained of tetany-like contractures of the hands, which occurred when she was excited. She was found to have hyperpnea, and some distention of the stomach by gas or air. She died in a second attack of tetany. An electrocardiogram made before death because the heart sounds were impure, but examined after death, showed the correct diagnosis to be coronary arterial occlusion, whereas a clinical diagnosis of the hyperventilation syndrome had been made.

The syndrome was here as a superstructure.

TREATMENT

An understanding of the problem is of great aid in the management of patients with the hyperventilation syndrome. The hyperventilation exercise shows to the patient the part he, himself, plays in the initiation of his symptoms. The reduplication of symptoms is a dramatic demonstration. Following this demonstration, an explanation can be made to the patient in simple terms. The patient is told that similar symptoms in other patients have been relieved by adequate control of respiration. He comes to realize that, with some help, he can relieve his own distress. He also feels that the physician thoroughly understands his problem. When this confidence is established, it is easy for more intimate contact to be made in order to institute psychotherapy, the success of which depends on rapport.

The prescription of acid salts, such as ammonium chlorid to the amount of 6 to 12 grams a day in capsules or in mixture of licorice, has been found to be of definite benefit. This regimen shifts the acid-base balance so that acid ions predominate. For immediate effect a phenobarbital compound may be used, but usually is not necessary. An acid-ash diet is to be given in all cases, and reduction of the intake of water is likewise of value. Some investigators have stated that the regular administration of the quinin drugs, hydrastin and yohambin, desensitize the nerve tissues to the continued action of adrenalin—which may explain the successful use of quinin as a "nerve tonic."

SUMMARY

It is the belief of the authors that many patients suffer from a group of symptoms which are directly traceable to the action, over a long period of time, of the emotions on the physical body. These symptoms are sometimes observed in association with those of organic disease. It is believed that such symptoms are the direct result of repeated overstimulation of the autonomic nervous system, which indirectly induces a state of alkalosis; and the alkalosis, in turn, aggravates the reactions already present and produces additional symptoms. The mechanism of the reactions is discussed, and a diagnostic procedure (the hyperventilation exercise) is described. The patients in whom this syndrome has been observed had complained of tetany or convulsions, or of symptoms simulating those of angina pectoris, asthma, peptic ulcer, thyrotoxicosis, Raynaud's syndrome, and Mèniére's disease. When the hyperventilation is found to be present, adequate treatment consists of instituting proper ventilation, the use of acid salts, such as ammonium chlorid and of an acid-ash diet, and the removal of the underlying anxiety by psychotherapy.

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DISCUSSION

Edwin L. Bruck, M.D. (384 Post Street, San Francisco).—For the last several years we have been interested in the symptoms presented by a small number of individuals, who have been usually characterized as neurotics. Many times these persons present themselves with the story that they are nervous, and that they have tingling and numbness of the four extremities, with occasional cramping of each of the feet or hands or both. Many times they may have also circumoral tingling.

When this train of symptoms is obtained in the history taking, they can be usually brought out in an exaggerated form or reproduced by the hyperventilation test as described by the authors. Most unusual symptoms may be produced in susceptible individuals with this test.

One may easily prove that such symptoms may be lessened or stopped through the rebreathing of carbon dioxid by the simple expedient of having the patient breathe and rebreathe into a large paper bag. Psychic origin of this chain of events cannot be denied in some cases, as they often appear in a hypertonic individual suffering from an anxiety neurosis.

However, the anxiety neurosis is not a necessary forerunner of this symptom-complex. Overbreathing from any cause will contribute to it, as in one patient of ours who could bring about the entire chain of events, even to the point of cramping in the hands, by a protracted spell of laughing.

There is, however, a chemical reason for production of these symptoms, often a self-induced alkalosis by the overindulgence in alkaline medications, usually brought to the attention of the laity through overzealous radio advertising. Likewise, the loss of chlorids, either through diuresis, sweating, vomiting or diarrhea, may produce a border state from which the individual is easily thrown into alkalosis, by minor overbreathing, giving rise to the usual symptom-

complex. It is also of interest to note that tissue hydration produced by intake of large amounts of water in susceptible individuals may produce some effects similar to those of alkalosis. Dederding and Fürstenberg have elaborated on this problem in their outlines of treatment of Menière's syndrome.

The authors have brought to our attention, forcibly, new criteria for the diagnosis of the alkalotic state, and have suggested efficient and simple modes of therapy which, in their hands and in ours, have produced beneficial results.

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MAYO H. SOLEY, M.D. (University of California Medical School, San Francisco).—Most physicians seeing consultation cases realize that two-thirds or so of their patients will have symptoms not directly related to any organic disease. Few of these physicians, however, have attempted to correlate the symptoms in their patients with the physiological effects of anxiety. Cannon, as long ago as 1915, demonstrated the effects of emotions on humans as well as on experimental animals. Since that time the spastic colon and hyperventilation syndrome have been added to the already recognized physiological effects of anxiety. The explanation that the symptoms of overbreathing are real, and can be reproduced, and that they are based on a fear mechanism, gives us a new and sound approach in the therapy of patients suffering from this condition. The intensity of the symptoms predominating in one system often makes the diagnosis difficult, but this predominance can be explained by the patient's fear of disease of that system with consequent exaggeration of sensations which he believes arise there. Usually, however, all of the characteristic symptoms from overbreathing can be obtained without asking leading questions, and point one to the correct diagnosis.

It should be stressed that treatment of patients suffering from anxiety states complicated by the hyperventilation syndrome with sedatives, acidifying drugs and diets, is merely a temporary measure to carry the patient along comfortably, while psychiatric investigation of the underlying fear is undertaken.

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SAMUEL D. INGHAM, M.D. (727 West Seventh Street, Los Angeles).—Phychiatrists are encouraged to observe that internists are showing more and more interest and appreciation of psychiatric problems and their intimate bearing on the problems of internal medicine. It has long been realized, but not widely appreciated, that emotional states are invariably accompanied by characteristic variations in the functions of the vegetative nervous system, and the widespread physiological and biochemical reactions that result. It is still impossible, however, to reduce these reactions to simple formulas or to correlate them accurately in clinical analysis. We know, in a general way, that the acute emotional reactions run parallel to increased activity of the orthosympathetic, and inhibition of the activity of the parasympathetic systems. We know less, in fact very little, in a quantitative way, of the biochemical effects of the more prolonged or chronic emotional states, or moods, such as anxiety, grief, and the depressive states. This problem includes the evaluation of the physiological changes which may be observed in relation to the circulatory, respiratory, gastro-intestinal, genito-urinary, and endocrine systems; of the biochemical processes incident to each of the physiological changes and of their interrelations, and of the progressive effects of prolonged action of these processes which result in malnutrition, deranged endocrine balances, and even actual pathological tissue changes.

The problem also includes the analysis of the individual patient in terms of heredity, constitutional type, environmental experimental experiences, general health, and his immediate personal problems, which may be the cause of his emotional state.

It is probably true, as the authors suggest, that when the internists have solved these problems, the specialty of psychiatry will have lost its identity; but the internists will then have more on their hands to do than to correlate physical findings with laboratory reports, if they do their full duty to their patients!

DIABETIC SURGERY*

A TEN-YEAR SURVEY

By IRVING WILLS, M.D.
AND
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Santa Barbara

DISCUSSION *by Emile Holman, M.D., San Francisco; William C. Boeck, M.D., Los Angeles; James B. Graeser, M.D., Oakland.*

THE hazards attendant upon surgery in the diabetic patient in the pre-insulin era were such as to cause the surgeon to approach procedures of any nature in this group of patients with grave misgiving. That potential hazards still remain cannot be questioned, but the great advances made in the understanding of the physiology and chemistry of this disease have effected improved methods of treatment and have done much to dispel earlier fears and to furnish a satisfactory solution to the problem.

MATERIAL REFERRED TO IN THIS REPORT

In presenting this survey of diabetic surgery carried out in a small community, it is our purpose to point out the value of close coöperation between the surgical and medical departments, and to express our firm belief that success in the management of the surgical diabetic patient is largely the result of such coördinated effort.

During the ten-year period from January 1, 1927, to January 1, 1937, a variety of surgical procedures have been practiced upon a large group of diabetic patients. In all, 177 (Table 1) operations have been done on patients selected from the Metabolic Service of Dr. W. D. Sansum at the Santa Barbara Cottage Hospital and the similar service of one of us (P. A. Gray) at the Santa Barbara General Hospital. These patients represent a cross-section of private and charity clientele, showing all grades of severity of diabetes, and the operations performed are a cross-section of those to be encountered among such a group of patients.

PREDISPOSING SURGICAL FACTORS

It is a well-known fact that surgical conditions arise in the diabetic more often than in the non-diabetic patient. Among the factors responsible for this are (1) the age of the patient, (2) increased susceptibility to infection, (3) the frequent occurrence of acidosis, (4) delayed healing, and (5) cardiovascular-renal disease. In other words, the diabetic patient not only is liable to any disease to which anyone else in his age group is subject, but also, because of his diabetes, has a pronounced tendency to gangrene and infection. We feel, therefore, that the apparently higher mortality in this type of surgery is not due to the disturbed metabolism *per se;* and that diabetes adequately controlled should not materially influence the surgical risk. This belief has been borne out not only in our experience, but also in that of surgeons in the larger clinics.

* Read before the General Surgery Section of the California Medical Association at the sixty-sixth annual session, Del Monte, May 2–6, 1937.

TABLE 1.—*Operative Procedures—1927-1937*

Major		Minor	
Amputations	30	Tonsil	63
Abdominal:		Tonsil and adenoid	11
Pelvic	19	Carbuncle	7
General	16	Cataract	3
Urologic	7	Antrum	3
Breast	4	Various	6
Thyroid	3		93
Perineal	4		
Chest	1		
	84		

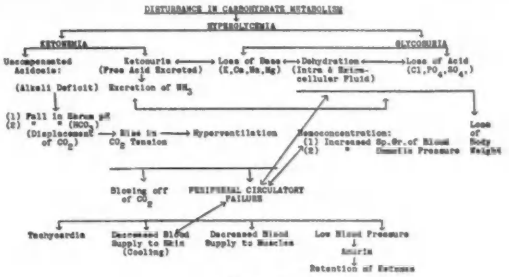

Chart 1

IMPORTANT SYMPTOM COMPLEX

Although this paper is not concerned primarily with surgical diagnosis, mention should be made of a diagnostically important symptom complex peculiar to the diabetic. While the student of diabetes is well acquainted with the picture of the "acute abdomen" simulated by diabetic acidosis, the general surgeon has little opportunity to study this interesting picture. Beardwood [1] and Baker [2] have recently reviewed this syndrome. Diabetic acidosis may produce a clinical syndrome resembling exactly the "surgical" abdomen, with nausea, vomiting, localized rigidity, fever and leukocytosis and, upon occasion, pyuria and hematuria. Case 1, cited below, is an illustration in point. This phenomenon has been explained upon several bases: (1) a sodium chlorid deficiency, (2) acute pancreatitis, (3) reflex irritation from spinal centers, and (4) gastric dilatation. Of these four hypotheses, the first has impressed us most. The symptoms described can be reproduced by states of dehydration and mineral deficiency paralleling those known to exist during diabetic coma. Relief of the abdominal pain has followed the intravenous administration of normal or hypertonic saline solution before the acidosis has been eliminated or the blood sugar lowered.[3]

Since diabetic acidosis alone may simulate a variety of surgical conditions in the abdomen, and since coma may equally well be precipitated by a pyogenic process in the abdomen, the differentiation between primary and secondary coma in a patient presenting abdominal symptoms becomes a nice diagnostic problem. The risk of operating upon patients in acidosis is such as to deter the surgeon from immediate operation, even though the patient may be admitted with abdominal symptoms. Almost any surgical condition, even a ruptured viscus, will permit of an hour or two delay. In this interval energetic treatment with fluids, sodium chlorid, glucose, and insulin should reduce the ketosis. If after a reasonable period there has been no change in the abdominal picture, or if it has become worse, exploration of the abdomen is justified. If, however, the nausea and vomiting have ceased, the abdominal pain and rigidity have vanished, and the fever subsided, surgery may wisely be postponed.

Since the leukocytosis may be due to hemoconcentration, estimation of hemoglobin and red-cell count, as well as the leukocyte count, should be made on admission and at frequent intervals thereafter. As the patient's water balance is restored with fluids, the total white count should fall. If it does not, we regard this as evidence of infection.

Table 1 shows that 177 major and minor operations have been done. The majority of the majors have been done by one of us (Irving Wills) and his surgical associates. This group will be considered predominately in this report. Especial consideration will be given to the groups of amputations and laparotomies.

PERIPHERAL CIRCULATORY COLLAPSE

From the metabolic viewpoint the gravest risk involved in diabetic acidosis is peripheral circulatory collapse, or so-called "medical shock." Peters [4,5] and Atchley [6] and their associates have studied the biochemical changes occurring in diabetic acidosis in elaborate detail. Lande,[7] Lawrence,[8] and others, have contributed to our knowledge of this clinical picture. Moon [9] has discussed the fundamental physiological unity of both medical and surgical shock. Understanding of the chemical and physiological processes involved will not only facilitate the management of the patient in diabetic coma, but also arm the surgeon against the complication of vasomotor collapse. The studies cited have shown fairly well that the clinical picture of shock results from a discrepancy between the volume of the vascular tree and the blood which it contains. In diabetic ketosis this discrepancy is due to the reduced blood volume consequent to the extreme dehydration. (Chart 1 illustrates the sequence of events diagrammatically.) Dehydration, hyperventilation, and cooling contribute to peripheral circulatory collapse. The first of these three factors can and should be combated by large volumes of fluid, preferably saline, to restore the depleted mineral base, which fluid can be given intravenously. Whole blood or acacia solutions, with their higher osmotic pressure and, hence, less likelihood of escaping through the capillaries damaged by anoxemia, may be preferable in emergencies. The second factor will disappear as the alkaline reserve is raised, and the third factor can be combated by the external application of heat. The patient's blood pressure is an excellent and simple clinical guide to the presence or absence of peripheral circulatory collapse, and should be incorporated into the routine care along with the blood sugar and CO_2 determinations. As already noted, we have recorded it at frequent intervals in all cases. Since the fundamental metabolic defect in this picture is dehydration, adequate amounts of fluids intravenously are freely justified.

AMPUTATIONS

The subject of amputations will always occupy a place of primary importance in diabetic surgery because of the frequency of gangrene and infection. These complications will probably remain prevalent because of the high incidence of arteriosclerosis, and the fact that a fairly large number of mild cases of diabetes go unrecognized and untreated year after year. In the surgical treatment of gangrene we see no particular advantage in making a distinction between the dry and the moist varieties, aside from the fact that the dry type usually does not present such an acute problem. To consider this type as uninfected is likely to invite trouble. It has seemed more rational to consider both types of gangrene as potentially infected, to determine if possible the presence or absence of septicemia, to examine the extremity carefully for signs of lymphangitis, and to suit and time the operation to the conditions present.

A high amputation has been the operation of choice in most of the cases. The advanced age of most of the patients, coupled with the inadequacy of their circulation, as demonstrated by oscillometric readings, makes this apparently radical procedure the one of choice.

Although most of our amputations have been through the mid-thigh, we have come to favor for selected cases the Callander modification of the Stokes-Gritti operation. This procedure possesses certain definite advantages, in that it neither exposes nor injures the muscle bellies, thus reducing the probability of infection. Furthermore, it gives a good weight-bearing stump without the necessity of uniting the patella with the end of the femur, as is the case in the Stokes-Gritti operation. In infected cases, showing advanced lymphangitis, a guillotine amputation above or below the knee may be a definitely life-saving procedure. It is our opinion that the patient's ability to walk later should not be given too much consideration when an amputation is contemplated. The life expectancy of many patients suffering from gangrene is short at best, and this fact, coupled with the increased risk of a subsequent higher amputation, does not justify the attempts often made "to save as much as possible." For those patients who are otherwise able to use it, a satisfactory prosthesis can be obtained to fit the high amputation stump. An analysis of the subsequent course and life expectancy of the patients in this group will be presented in a later communication.

The elaborate preparation of the leg for amputation has received considerable attention by various writers. We have been opposed to any active scrubbing or manipulation of the part, feeling that the milking action incident to vigorous cleansing may tend to spread bacteria from the unclean zone into an otherwise clean area. Our practice has been to cover all but a minimum amount of skin at the site of amputation and prepare this area with a generous coating of tincture of iodin. No other preparation has been used or considered necessary. The tourniquet has never been employed because of its devitalizing effect on the tissues and of the tendency to late oozing. By working as a team, the surgeon and his assistant can control hemorrhage so that only a relatively small amount of blood will be lost. Drainage, which was formerly used routinely, has not been employed recently. The wounds have been closed loosely with only a few interrupted sutures in the fascia and silkworm in the skin.

No special diabetic preparation other than control of ketosis when present has been necessary for those patients about to have an amputation. An adequate amount of fluid by mouth or hypodermoclysis has been insisted upon. Since about half of the amputations have been done under spinal anesthesia, especial check upon the blood pressure has been kept postoperatively. The first regular meal hour after operation has usually been omitted; thereafter the usual diet, converted into soft foods and liquids, has been served. Insulin has been given on a four-hour schedule, the amount depending upon the blood sugar, which should be kept between 100 and 150 milligram per cent.

LAPAROTOMIES

Most of the laparotomies performed have been elective and, needless to say, on patients that have been carefully selected. These patients have represented, for the most part, individuals from the "middle class" who have been under continuous diabetic supervision. In acute abdominal conditions, such as appendicitis, the importance of early operative interference cannot be stressed too greatly. Control of diabetes is difficult in the presence of acute infection, and the insulin requirement is temporarily increased. Drainage of the wound has been effected in these cases the same as in nondiabetic patients.

Whenever possible, laparotomy patients have been hospitalized several days prior to operation. Normal blood sugar levels have been considered desirable, but have not always been practicably obtainable. No patient has been allowed to go to surgery with a CO_2 level below normal. Fluids have been forced the day or days prior to operation, and 5 per cent glucose in normal saline solution has been given by hypodermoclysis the morning before surgery. (Table 2 shows the type of anesthesia which has been selected in this group of patients.) After the operation the patient's blood pressure has been taken at hourly intervals, the blood sugar determined at two hourly intervals (usually by the Folin-Wu method on capillary blood), and the urine tested whenever available. Because of the risk of infecting the bladders of diabetic patients,[10] we have refrained from catheterizing the bladder for the purpose of obtaining specimens.

On the first postoperative day a minimum of 3,000 cubic centimeters of fluids have been administered by vein or hypodermoclysis. At least 100 grams of glucose have been given as 5 per cent glucose in sodium chlorid solution the first twenty-four hours. A sufficient amount of insulin has been given to hold the blood sugar between 100 and 200 milligram per cent. Patients whose stomachs or bowels have been incised have received nothing by mouth for forty-eight hours. Others

TABLE 2.—*Anesthesia Selected*

	Spinal	Gas-Oxygen	Gas-O_2-Ether	Local	Ether	Gas-Amytal (Ether)
Abdominals General	4	2	5	3	1	1
Pelvic	2	3	11		2	1
Amputations	12	10	9	3		3

have received fluids (water, ginger-ale, sweetened tea, and water-packed pear juice, flavored with lemon) on the second day. Also on this day skim milk and white of hard-cooked egg have been given to some patients. On the third day, broth and junket have been added. On the fourth or fifth day, pureed bland fruits and vegetables, rice, potatoes, and melba toast have been permitted. Postoperative "gas" pains have been no more troublesome in this group of patients than among the nondiabetic group. The total calories fed per day have not exceeded 1,500 in any case as long as the patient remained at bed rest.

Each day enough fluid has been given to equal the volume of the twenty-four-hour urine specimen, plus 1,500 cubic centimeters (to allow for perspiration). In the more severe cases, insulin has been given every two hours in doses of five and twenty units; in the milder ones, every four hours in similar doses.

Preparation of the skin for laparotomy has been the same as for the nondiabetic patients, and since we have only one instance of wound infection (in the County Hospital), our technique may be assumed to have been adequate.

Included in this group of patients are four instances of cesarean section (done on primiparae) by Dr. L. F. Eder. Three of these included sterilization. There has been no maternal mortality, and only one fetal death from a congenital cardiac anomaly. The postoperative course of these four patients presented no unusual surgical problems. Control of their diabetes was maintained by capillary blood sugar determinations at two-hour intervals.

No surgical mortality has been encountered among the thirty-five patients who have undergone laparotomies. All left the hospital in good condition. Some have died since from causes unrelated to the surgical procedure practiced.

ANESTHESIA

Anesthesia is a subject about which there has always been considerable diversity of opinion, but with a better understanding of the action of the various anesthetic agents on carbohydrate metabolism those experienced in the surgery of diabetes have come more and more into agreement in the past few years.

Procain preparations, whether used intraspinally or as local infiltration, apparently have no deleterious effect on metabolism. Nitrous oxid and ethylene interfere in the carbohydrate metabolism, as shown by elevation of the blood sugar, accumulation of lactic acid in the blood and reduction of the alkali reserve of the blood.[11] However, these changes are slight if the duration of the anesthesia is not prolonged. Although nitrous oxid combined with ether produces even more marked changes, it may still be used safely if steps are taken to combat the ensuing acidosis. Ether should be used sparingly upon the diabetic patient. Although desirable from a chemical point of view, local infiltration of tissues may be undesirable from a mechanical one, because the devitalizing effect of the trauma to the tissues will favor the development of infection. Nitrous oxid and oxygen give poor relaxation, hence are unsatisfactory for most abdominal procedures. Our preference for all operative procedures on the lower extremity, perineum, lower urinary tract and lower abdomen has been spinal anesthesia. We have used 50-150 milligrams of novocain, dissolved in 1 to 3 cubic centimeters of spinal fluid, depending on the height and duration of analgesia desired. Ephedrin has been used routinely as a pre-anesthetic medication. In the upper abdomen we have usually used local infiltration of the skin combined with nitrous oxid and oxygen. In the younger patient who is free from demonstrable cardiac disease, spinal anesthesia may occasionally be used here as well.

For operations about the head and neck, including thyroidectomy, local infiltration, nitrous oxid or a combination of both have been preferred.[12-21]

REPORT OF CASES

CASE 1.—F. H., a girl, age eleven, had had a severe grade of diabetes for two years. Dietetic control had been imperfect. Twenty-four hours before admission to hospital she developed pain in the right lower quadrant of the abdomen, associated with nausea and vomiting. Insulin had been discontinued. On admission she was comatose. Body temperature was 101 degrees, respiration 30, pulse 35. The skin was dry. No cyanosis was observed. The breath reeked with the odor of acetone. The abdomen was soft, except in the right lower quadrant, where tenderness and rigidity were present. The urine contained albumen 4 plus, sugar 4 plus, acetone 4 plus, and diacetic acid 4 plus. The blood sugar was 440 milligram per cent, and the carbon dioxid combining power of the plasma 24 volume per cent. The blood count was: Hemoglobin, 97 per cent; red blood cells, 4,740,000; white blood cells, 23,350.

One and one-half hours later all spontaneous pain had left the abdomen, and no rigidity nor tenderness could be detected over McBurney's point. Her temperature had fallen to 98 degrees. After four hours her condition was greatly improved. The white blood count had fallen to 19,600. The urine contained sugar plus, acetone plus, diacetic acid 0. The blood sugar was 184 milligram per cent. Eighty units of insulin and 1,000 cubic centimeters of normal saline solution had been given. Recovery was uneventful. There has been no recurrence of the right lower quadrant pain to date.

* * *

CASE 2.—C. M., woman fifty-seven years old, was known to have had diabetes for five years. For five months before admission she had suffered from recurrent attacks of "acid type" of pain in the epigastrium one hour after meals.

Vomiting had brought relief. This had increased in frequency recently. Normal acid values for gastric juice were obtained. No abdominal mass could be palpated. Blood counts and the blood chlorid were normal. Gastro-intestinal x-ray examination revealed a highly obstructing lesion at the pyloric end of the stomach. Laparotomy under gas-oxygen ether revealed a greatly enlarged stomach, with a thickened and edematous wall. There was a firm cicatrix involving the first portion of the duodenum and completely obliterating the lumen. Posterior gastro-enterostomy was done. Sections of an adjacent lymph node revealed no evidence of malignancy. The incision healed by first intention and the postoperative course was uneventful.

Repeated gastric lavage had kept the stomach empty for several days prior to operation. One hundred to one hundred and fifty grams of glucose had been given daily (as 5 per cent glucose in normal saline). To each intravenous injection five units of insulin had been added. No food or fluid was given by mouth the first twenty-four hours after operation, and only chipped ice the second. Two thousand to three thousand cubic centimeters of 5 per cent glucose in normal saline were given each of these days. Forty-five units of insulin were required the first postoperative day and eighty the second, in order to keep the blood-sugar level (taken at four-hour intervals) below 200 milligram per cent. On the third day, skim milk and water were tolerated by mouth, and subsequently the usual bland diet. The diabetes was controlled at discharge with a maintenance diet and ten units twice daily.

* * *

CASE 3.—M. S., a woman, age fifty-one years, had been under treatment for diabetes mellitus for one year prior to surgical interference. She had been sugar-free on a diet of C. 407, P. 110, F. 103, calories 2,995, with insulin units 18-3-10 daily. Attacks of sharp pain in the right upper quadrant of the abdomen, radiating to the shoulder blade and associated with nausea and vomiting, had been frequent. She had never been jaundiced. Three attempts to elicit a gall-bladder shadow by oral administration of dye had failed. A normal icteric index and bromsulphthalein test had been obtained. Cholecystectomy was done under local and gas-oxygen anesthesia. A "white" gall bladder attached to the duodenum with adhesions was removed. The incision healed by first intention and the postoperative course was uneventful.

On the morning of the operation, the patient's usual insulin dose and breakfast were omitted. She received 1,000 cubic centimeters of 5 per cent glucose in normal saline solution plus 10 units of insulin before going to the operating room. On the first postoperative day, 45 units of insulin and 165 grams of glucose as 5 per cent glucose in normal saline were given. On the second day, 1,100 cubic centimeters of the bland fruit juice and water were tolerated by mouth; in addition she received 2,000 cubic centimeters of normal saline by hypodermoclysis. On this day 35 units of insulin were required. On the third postoperative day, 35 units of insulin and 3,250 cubic centimeters of fluids were given. On this day, also milk, bouillon, junket, and egg white were tolerated by mouth. At discharge from the hospital the diet was: C. 286, P. 104, F. 71, calories 2199. She was sugar-free with insulin 22-7-19 units.

* * *

CASE 4.—E. G. A., woman, age fifty-six years, had had diabetes for twenty-two years. Diet had not been followed and insulin had been refused. She had had an infected "corn" on the right fifth toe for one year. Pus had drained from this lesion intermittently during that time. One week before admission the calf of the right leg had become swollen and painful and the skin red. At the same time a tender swollen mass had appeared in the left forearm. Heat had been applied to the forearm. Blisters had resulted over the volar surface and at the elbow. Thirst, appetite, and urination had increased perceptibly the week before admission.

On admission the entire left forearm was swollen, red, and tender. Many oval necrotic areas were present on this surface and one covered the elbow. The forearm was flexed 90 degrees on the upper arm. The patient could not close her fingers. The fifth toe and lateral surface of the right foot were bluish black. Pus exuded from the base of the fifth toe. The dorsum of this foot was edematous. A hard, tender mass was present in the bellies of the gastrocnemius muscle. No red streaks were noted, but enlarged, tender glands were found in the right groin. Body temperature on admission was 100.8 degrees. The urine contained sugar 4 plus, acetone 3 plus, and diacetic 2 plus. The blood sugar was 590 milligram per cent. The white blood cells were 14,650.

The patient was prepared for surgery in the usual fashion. Three days after admission a Callander amputation was performed under spinal anesthesia. The whole posterior aspect of the removed leg was found to be diffusely infiltrated with pus. Healing was uneventful.

Fifteen days after admission the lesion in the left forearm had become localized. Through and through drains were inserted after incision and evacuation of pus. Healing was uneventful. The patient was discharged from the hospital controlled on C. 167, P. 76, F. 82, calories 1,710, with 25 units of insulin twice daily.

CONCLUSIONS

Analysis of the chemical, physiological and mechanical problems presented by surgical treatment of the diabetic patient suggests certain conclusions:

1. The surgical diabetic patient is primarily a medical problem.

2. The surgeon must be "diabetes minded," and willing to work in close coöperation with the internist.

3. A thorough understanding of acidosis and peripheral circulatory collapse is essential to successful treatment.

4. The choice of anesthetic should be individualized.

5. Diabetes in the surgical patient should not greatly influence the operative risk.

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DISCUSSION

EMILE HOLMAN, M.D. (Stanford University Medical School, San Francisco).—Only complete agreement with the authors is possible in their able treatment of the need of fluids, and more fluids, in the care of the diabetic. Too often but a minimum attention is paid to the importance of maintaining in all conditions of illness or operative care an adequate fluid supply to insure a proper balance between intake and output. It is only recently that total blood volume has been accorded the importance it deserves, particularly in the period of water deprivation that precedes any operation to be performed under a general anesthesia. Patients are denied replenishment of body fluid at the time of greatest need. Accordingly, it cannot be too strongly emphasized that before any major operation the deprivation of water by mouth should be counteracted by either subcutaneous or intravenous infusions—given *before* operation as well as *after* operation.

The site of amputation is determined by the extent of infection, the severity of arteriosclerosis, the degree of patency of arteries and, obviously, by the amount of demonstrable gangrene. Occasionally, in the presence of a partially gangrenous digit, largely the result of infection which has developed in spite of palpable dorsalis pedis and posterior tibial arteries, we have been content to control the diabetes, and later perform an amputation of the toe. Gangrene and infection of the foot occur on occasion in the presence of a very vigorously beating popliteal vessel. Amputation below the knee has been performed and good healing obtained. Mid-thigh amputations are obviously preferable in elderly patients, with extensive obliteration of the vascular tree.

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WILLIAM C. BOECK, M.D. (1919 Wilshire Boulevard, Los Angeles).—This paper, recounting the experience of the authors in the medico-surgical treatment of diabetic patients requiring operation, illustrates most beautifully how excellent results are obtained by the coöperation of the internist and surgeon. These splendid results in this study were secured because both the internist and surgeon were familiar with the fundamental necessities of the preoperative, operative, and postoperative care of the diabetic patients, not only from the medical but from the surgical viewpoint as well. It follows, therefore, that while it is desirable for internists and surgeons to coöperate in the care of these diabetic surgical patients, yet the results will not be ideal if either one is lacking in the knowledge required of each. The internist should know the medico-dietetic management of diabetes in order that the diabetic state may be balanced and controlled, and that any disturbance in body chemistry may be completely corrected, or as nearly as possible. The surgeon, on the other hand, must also have this knowledge in part and, above all, should have had experience in diabetic surgery. This will enable him to make a wise selection of the type of anesthesia, operation, and with the internist he will see that the postoperative care is proper in order to avoid complications and possible death from coma.

Fortunately, most operations upon diabetic patients are elective, and only occasionally is an emergency operation necessary. Therefore, there is adequate time to control the glycosuria of the patient by diet and insulin if necessary. No patient should be submitted to operation unless his diabetes is well under control. If this is not done, and the operation is performed while there is marked glycosuria and a high blood sugar, acidosis and probably coma will ensue postoperatively, since operations like infections increase the severity of the diabetes.

It follows that diabetic patients who have been operated upon must be followed closely after operation and their glycosuria cleared up by adequate insulin dosage, along with the other items of postoperative care as given in this paper. I do not feel it is necessary, however, to do this by repeated blood-sugar determinations as practiced by the authors. On our own diabetic service we find it only necessary to have blood-sugar determinations at four to six hours postoperatively, perhaps again at ten or twelve hours, and then at intervals of twenty-four hours. We are able to ascertain the diabetic state by urinalysis for sugar alone, and prescribing insulin as necessary at intervals of one or two hours. In order to carry out such examinations, we employ indwelling catheters in our patients, and to date there have not been any urinary infections following such procedure.

I wish it were possible for all diabetic patients to have the coöperation of both internist and surgeon whenever surgery, such as was accorded the patients upon which this paper is based, is necessary. Too frequently the surgeon acts alone, and asks the dietitian for a "diabetic diet" with no prescription as to carbohydrate, protein and fat constitution. Insulin is given, but often not enough to control the glycosuria, or to clear up the acidosis before the operation is performed, with the results that the patient may never awaken, death occurring from diabetic coma. It is sad, indeed, to know such occurrences are still taking place in some of our hospitals, for it is no improvement over pre-insulin days. Too bad, perhaps, that the surgeon was not familiar with the book "Diabetic Surgery," written by McKittrick and Root. Would it be asking too much if the hospitals had, as a requirement, that all diabetic patients who are to be operated upon must have consultation from an internist trained in diabetic management, even as we make it mandatory that internists consult upon cases of therapeutic abortion? Certainly, the demand is equally as important from the standpoint of the patient, the hospital, and the physician in charge.

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JAMES B. GRAESER, M.D. (2940 Summit Street, Oakland).—Although general principles of procedure may be discussed in a paper of this type, it is impossible to summarize or present accumulated experience, except in its broader aspects. As stressed by the authors, success in this particular field is dependent upon the combined effort of the internist experienced in handling diabetes under surgical conditions and the surgeon who is "diabetically minded." In elective operations a severe diabetic may be prepared for operation and controlled in the postoperative period with but little disturbance. The emergency operation in poorly controlled cases, on the other hand, presents a hazard greatly increased by the diabetic factor.

The authors' discussion of the postoperative care of laparotomies presents a model procedure.

MEDICINE AND NATIONAL POLICY*

By MORRIS FISHBEIN, M.D.
Chicago, Illinois

SINCE the earliest times the care of the public health has been recognized as of the greatest importance in the maintenance of any nation. As long ago as 1875, Dr. Henry Bowditch suggested that the American Medical Association support the appointment of a Minister of Health in the cabinet, and this was adopted by the House of Delegates in 1876. Today it is recognized that our government—federal, state, and local—is already intimately concerned in matters of health. Of the two million beds available for medical care, almost a

* A digest of the address given at the annual meeting of the Los Angeles County Medical Association on December 2, 1937, by the editor of *The Journal of the American Medical Association*. From the *Bulletin* of the Los Angeles County Medical Association.

million are in government-controlled institutions. Our federal departments have many medical functions such as the United States Public Health Service in the Treasury Department, the Food and Drugs Administration under Agriculture, Maternal and Child Welfare in the Labor Department, the care of the Indians and institutions for the insane in the Interior Department, Coast Guard in the Department of Commerce, and many other functions scattered under some of the special commissions. Yet today the vast majority of the care of the people of the United States in illness rests on the practitioners of medicine, a burden which they have voluntarily assumed and one which they do not propose to relinquish until they are satisfied that some other system will give better medical service to more and more people.

FOREIGN STATE-CONTROLLED SYSTEMS OF MEDICAL PRACTICE

In the organization of many foreign nations state-controlled systems of medical practice have been introduced to meet conditions which prevailed among their peoples. There is no good evidence that any one of these systems is yet recognized as an answer to the problem of adequate medical service for all of the people. The most that can be said for any of them is that it is an improvement on what those people had before. Today under our system of medical care we have the lowest rates for death, for infant mortality and for most of the infectious diseases that prevail anywhere in the world. Is there any good evidence that a radical change in our plan of medical care would bring about still further advancement? Actually the evidence seems to indicate that any fundamental revolution would depreciate the quality of medical care, inhibit initiative, and at the same time vastly increase the costs of the service rendered.

EVOLUTION OF MEDICAL PRACTICE IN AMERICA

Our system of medical care is a logical evolution of personal medical practice to meet every need as it has arisen—a process of evolution which still goes on, adapting itself smoothly to the needs of the new mechanized civilization. For every new problem organized medicine has developed its advisory councils, and these have consistently sought for higher standards and a wider application of the best available medical care. The Council on Medical Education and Hospitals has done more to raise the standards of medical education and hospital service than any governmental agency has accomplished or could accomplish. It accomplishes more by voluntary action with high ideals that could be achieved by any federal agency slowly unwinding the red tape of governmental inspection, and forcing action by the labored processes of legal procedure. Education and voluntary action in the field of health have invariably brought about great reforms with more facility than have been achieved by the pressure of confused, hasty and unscientific legislation.

THE FERMENT OF 1927: WHAT IT HAS GIVEN US

Since 1927 a ferment has been agitating the medical scene. It is the new concept of social service and the apotheosis of the so-called underprivileged. It is a social philosophy which places the needs of four or five million indigents, many of them trained to indigency by superlative coddling, above the health and welfare of forty million workers and their families. The campaign has been waged with abuse and vilification of the medical profession, with blandishments and appeals to cupidity, with slogans and with threats. We have heard that "everyone is entitled to the best of medical care for a price that he can afford to pay," an ideal never yet realized in any nation or in any community in this world. We have been told that the "doctors must develop a plan or the Government will develop one for them." In response the physicians have developed hundred of plans now being tried in many communities, knowing that there is no single formula or ritual that will answer for every community any more than there is a panacea for every syndrome or complication of symptoms.

SOME "FOUNDATION PROPONENTS" OF COMPULSION HEALTH INSURANCE

The Milbank Foundation promoted compulsory sickness insurance, spending many hundreds of thousands of dollars in its promotion, and it has departed from such propaganda as one of its functions. The Rosenwald Foundation has spent equally for at least a decade in promoting hospital insurance, and today less than one per cent of our population has chosen to avail itself of such insurance and the Rosenwald Foundation has closed up its department of medical service. Mr. E. A. Filene urged a half-dozen different panaceas through the Twentieth Century Fund, and the latest activity of that group has been the development of coöperatives for medical care among employees of the Home Owners' Loan Corporation and among employees of the Federal Farm Loan Banks, with the concept that a few physicians employed full time can give adequate medical care to many thousands of people on a contract basis. No one has ever demonstrated that any such a system of medical care even approximates in quality the kind of medical service that is available to the majority of workers in the United States with even less income than is given to these employees of the Government.

AMERICAN FOUNDATION STUDIES IN GOVERNMENT

Now come the principles and proposals emanating from the studies of the American Foundation Studies in Government. Behind these principles and the signatures of the 430 physicians who signed them is a record of political manipulation which should be better known to the medical profession and to the people. This manifesto has been heralded as a "revolt" in the American Medical Association in behalf of state medicine. Yet in a

period of six months there were only 430 signitures and already great numbers of the signers have withdrawn their names. Today we know that the circulation of this manifesto was planned and designed to impress the executive and legislative branches of our federal government with the view that the American Medical Association is disorganized, nor representative of medical thought throughout the nation, and opposed to the best interests of the people. Who may profit from such evidence of disorganization? Is there any proof that self-appointed Committees of Physicians are any better able to represent the opinion of the American medical profession than the democratically chosen House of Delegates of the American Medical Association? The representatives of the 106,000 physicians who constitute the membership, the largest in the history of the Association, actually 80 per cent of the reputable practicing physicians of our country, have declared themselves opposed to any fundamental change or revolution in the development, distribution or payment for medical service. They await evidence from some of the many plans now undergoing experimentation in various places, that a new technique is desirable and safe for the people. That is the scientific method.

MINISTER OF HEALTH IN THE PRESIDENT'S CABINET

The impression has been circulated that the American Medical Association opposes a Minister of Health in the Cabinet. This is absolutely untrue, and represents again the manner in which truth is manipulated to place the medical profession in an unfavorable light. In reorganization of our federal government affairs at least three proposals have been made relative to the place that should be occupied by medicine and the care of the public health. What medicine fears is the possibility of a single ministry to be concerned with the care of the indigent, unemployment, social service, education and public health. Here there is the possibility a single Minister of Indigency may be made superior to health or education. Out of such an establishment will come inevitably worse confusion and less efficiency than we have ever had in the past.

SCIENTIFIC PLANNING NEEDED

Obviously what is needed now is not a *plan*, but *scientific planning*. At its annual session in June, 1937, the American Medical Association reaffirmed its willingness to do its utmost today as it has in the past, to provide adequate medical service to those unable to pay either in whole or in part. It has urged that in every county the county medical society take the leadership in calling into coöperation health departments, community chests, and social service organizations, to ascertain the needs in that county and to work out suitable provisions for meeting those needs. In June, 1937, the American Medical Association officially reaffirmed its willingness on receipt of direct request to coöperate with any governmental or other qualified agency and to make available the information, observations and results of investigations together with any facilities of the Association. Thus far no call has come from any governmental or other qualified agency for the coöperation of the American Medical Association in studying the need of all or of any groups of people for medical service, or to determine to what extent any considerable proportion of our public are suffering from lack of medical care. The offer still stands as evidence of the willingness of the American Medical Association to aid in finding solutions for the problems that now prevail.

WORK OF COUNTY MEDICAL SOCIETIES

In many places throughout the United States today county medical societies already assume fully the burden of medical care for the indigent. In some places, under the leadership of county medical societies, all agencies concerned with the care of the sick and with preventive medicine, are working on plans to extend such care and at the same time to avoid duplication, inhibit waste, and prevent neglect. The Social Security Board, charged with the handling of unemployment and old age insurance, is making extensive studies of sickness and its care, although not yet has there been any report from that body as to the needs of the people or any recommendation as to how these needs shall be met. If the answer is to be sickness insurance, as it has been intimated the Dodd report would have recommended in California, let it be remembered that under such a system the burden falls wholly, after all, upon the worker. He pays up to 3 per cent of his wages, the employer contributes an additional sum which is then added to the costs of goods that the worker buys, and finally the Government contributes a portion out of the taxes that the worker pays. The end-result is a bureaucracy with two new government employees for every physician who gives medical service, and a system of red tape which diminishes the amount and quality of service that the physician can give. And when the bills become too great the government makes it even by diminishing the amount of money paid to the doctor for his service, or by recommending that the patients have less attention and less medicine for the illnesses covered by the system.

AMERICAN MEDICINE TODAY

American medicine, now superbly organized on a democratic basis, speaking with the voices of more than one hundred thousand physicians, promises again to do its utmost in coöperating with all of the other agencies now available to supply a high quality of medical service for all of the people. In doing so, however, it must conserve those features of medical practice which time and training and experience have shown to be absolutely essential to a high quality of medical care. The best results will never be achieved by a revolution in the organization and administration of medical service. They must come by a steady, persistent evolution.

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CALIFORNIA VENEREAL DISEASE CONTROL PROGRAM*

By MALCOLM H. MERRILL, M.D.
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IT was in 1492 that syphilis was introduced into Europe. This disease raged entirely unchecked for over four hundred years. It was 1837 before it was finally demonstrated that syphilis and gonorrhea were two different diseases. In 1879, the minute germ which causes gonorrhea was discovered. The pale, thin spiral-shaped germ which causes syphilis was discovered in 1905 by a young German scientist by the name of Schaudinn. The blood test used in the diagnosis of syphilis was devised in 1907, and salvarsan, the drug which has proved so highly effective in the treatment of syphilis, was finally prepared in 1910. It was called 606 because 605 preparations were prepared and tried before the effective drug was found. We now have compounds containing arsenic that are closely related to salvarsan and are less toxic and almost equally as effective. In 1922, it was discovered that bismuth compounds were also highly effective in the treatment of this disease. During the years since then extensive investigations have shown the amount and duration of treatment necessary.

CAUSES KNOWN

We have known for twenty-five years the cause of these diseases; the mode of transmission or how they are spread; how they can be prevented, and in the case of syphilis we have had highly effective methods of treatment. For years we have had all the scientific information about these diseases that is necessary for their eradication. This is particularly true with regard to syphilis. Yet, what have we accomplished? While the application of our knowledge has worked wonders in the control of smallpox, diphtheria, typhoid fever and tuberculosis, the venereal diseases have continued to run rampant. These diseases, and particularly gonorrhea, are almost as prevalent today as they were at the turn of the century.

'Way back in 1895 there were instances of agitation for control measures by occasional physicians. But these received little attention. A pamphlet was prepared by the United States Public Health Service in 1908 in which these diseases were very conservatively discussed, but the pamphlet was returned, disapproved by the Secretary of the Treasury, with the following comment: "The matter contained in this bulletin is not in keeping with the dignity of the fiscal department of government."

FIRST EFFORTS IN CALIFORNIA

Feeble efforts at control were begun in 1912. In California, reporting was begun and a modest educational campaign was launched. However, little headway was made anywhere until the war. Then a nation-wide control movement was undertaken. Definite programs were developed in forty-six states under federal direction. The Bureau of Venereal Diseases was established in California in 1917 and then followed three years in which there was an extensive control campaign. A number of clinics were established. Wide publicity was given the movement and the incidence of the venereal diseases was undoubtedly held down as a result of this work. At that time, however, newspapers and popular periodicals were extremely hesitant in their discussion of the problem.

POST-WAR PERIOD

At the end of the war all federal funds were withdrawn and coördinated campaign collapsed. As occurred in other states, in 1920 the California State Department of Public Health was forced, because of lack of funds, to abandon its Bureau of Venereal Diseases. Despite this collapse of coördinated activity there remained throughout California a number of islands of activity in the form of programs within local health departments, for example, in San Joaquin County, San Diego, Long Beach, Los Angeles, and San Francisco. The activity of these local departments has continued since that time. Beginning about 1926, scientific interest in these diseases began to be intensified, and during the last ten years, under the direction of the United States Public Health Service, a tremendous amount of extremely valuable data has been collected. With the recent advent of Dr. Thomas Parran as Surgeon-General of the United States Public Health Service, a nation-wide campaign was begun. Fortunately, some funds were provided through the Social Security Act to make the movement possible. Of the eight million dollars allotted to the United States Public Health Service, approximately one million dollars has been allotted to states for the control of venereal diseases. Taking advantage of this, California reëstablished the Bureau of Venereal Diseases in February of this year and a state-wide control program was initiated.

APPROPRIATION BY THE 1935 CALIFORNIA LEGISLATURE

The recent session of our State Legislature adopted legislation and, through appropriation, added to the funds for the carrying on of the program. With the funds available, an active program for California is assured. There is a nation-wide program now under way. Almost every state in the Union is developing a special department for venereal disease control, and the movement is going rapidly forward. The United States Public Health Service is acting primarily in an advisory capacity to coördinate the national program.

In California the State Department of Public Health is similarly acting in an advisory and coördinating capacity to the local health departments. The aim is to assist in the development of effective programs within these local departments.

PREVALENCE OF THE DISEASES

How prevalent are these diseases? During the month of September, 1937, 1,897 cases of gonorrhea and 1,825 cases of syphilis were reported to

* From the Bureau of Venereal Diseases, California State Department of Public Health. Excerpts from an address presented at Veterans Memorial Auditorium, San Francisco, October 21, 1937.

the California State Department of Public Health. If this rate persists throughout the year, it would mean approximately 45,000 cases per year. About 75 per cent of new infections occur before the age of thirty years. From the results of surveys we have run in recent months we are now convinced that not more than 50 per cent of the cases are actually being reported. These same surveys have also indicated to us that there are constantly under treatment approximately 40,000 cases in California, or between four and six cases for 1,000 of population.

MONEY COST OF SYPHILIS AND GONORRHEA

It is impossible to estimate the cost of these diseases to the citizenry of California. It costs over one-half million dollars per year to maintain in our state hospitals patients afflicted with central nervous system syphilis. The cost of treatment of the 40,000 cases that are constantly receiving medical care cannot be estimated, but must be several millions of dollars annually. The loss incident to physical incapacitation and loss of time at work of this large army of people likewise cannot be estimated.

PAST EXPENDITURES

We have been interested in determining how much money is being expended to prevent these diseases. Before the advent of the present campaign the total expenditure by local health departments was approximately $200,000 per year or 3½ cents per capita for the people of the State. With the money now available this has been increased to about 5½ cents per capita. Local health departments that have fair programs under way are expending about 10 cents per capita. Most of this money heretofore has been used in clinic and laboratory service. Little effort has been made to find sources of infection or contacts and get these people under treatment. The Department was interested in knowing where their cases were receiving treatment. It was found that about 75 per cent are under the care of private physicians. Twenty-five per cent were being treated in free clinics. There are approximately eighty such clinics scattered throughout the State where treatments are being given. In July of this year 9,813 patients were under treatment in these eighty clinics.

PUBLIC HEALTH SUPERVISION OF PATIENTS UNDER TREATMENT

It has been found that there is a gross deficiency in the public health control of the 75 per cent of the cases that are under the care of private physicians. Only about 10 per cent of these patients have been reported to the health department, and there has been no coördinated effort to find the sources of infection or contacts in these cases. A large proportion of all patients have been found to lapse from treatment before treatment is completed. Many persons never get under the care of a physician at all, such patients placing themselves in the hands of quacks or attempting self-treatment.

EDUCATIONAL CAMPAIGN NEEDED

In the campaign against tuberculosis, smallpox, and diphtheria, education has been found to be the most important single factor. We have no reason to believe that an exception should be made in this respect in reference to venereal diseases. Consequently, an intensive effort is to be made to inform the public concerning these diseases. The Department wants the public to know the nature of these infections, their cause, how they are spread, and how they are treated. Literature is being prepared for wide distribution. Lectures, motion pictures, newspapers, and posters will be used. All this will help to insure close coöperation between lay organizations, physicians, and public health agencies. A fundamental phase of the educational program is the introduction of adequate instruction in our elementary and secondary schools and colleges. Such courses must be designed to give information about public health in general with venereal diseases being discussed along with other infectious diseases. This educational program is designed for two primary purposes. First, to prevent new infections from occurring; and second, to convince the public at large of the necessity of early medical care once infection occurs.

TREATMENT MUST BE AVAILABLE FOR EVERY PATIENT

Next to the educational program perhaps the most important factor is to assure that treatment is available for every patient. Proper treatment is fundamental in the control of these diseases so that infection may not be spread from the infected to normal individuals. In an effort to assure that treatment is available, clinic service will have to be made more adequate. Standards of treatment and the facilities in the eighty or so clinics are being improved, and the clinic periods are being extended. Free drugs are being distributed to private physicians in an effort to assist them in the care of indigent and part-pay patients. The treatment of syphilis is so effective that if we could bring all cases under treatment at the same time and continue treatment for the prescribed eighteen months to two years our problem would be practically solved.

ELEMENTS IN A STATE PROGRAM

In order to get as many patients as possible under treatment, extensive epidemiological work is necessary. Public health nurses will be assigned to various health departments throughout the State to assist the health officers in case finding and assuring continuation of treatment. You will be interested to know that about 80 per cent of all cases of syphilis lapse from treatment prematurely. This epidemiological work has tremendous possibilities, but also involves intricate problems in human relationships. Tact, care, and a humanitarian outlook are going to be necessary. The vast majority of patients will coöperate if they are made to feel that these are infectious diseases and that our sole interest is in the protection of themselves against late complications of the disease and the protection of their associates against infection. The Department is endeavoring to eliminate any element of social stigma or punishment in this approach. We are adopting the axiom, "What would we do if this were a case of smallpox?" and attempting to ap-

proach the problem in the same wholesome, scientific manner. Legal measures will be necessary, but we feel they will be required in rare cases only. We must have the legal power to enforce quarantine and isolation upon uncoöperative patients who are a menace to the public, especially those engaged in illegal activities. This power will rarely need to be exercised if the patient is made to understand our objectives and the reasons for our insistence upon their receiving treatment and abiding by regulations set down. Coercion must be our last resort, but it must be employed if the protection of the public is involved.

The program for the eradication of the venereal diseases is to be coördinated with other public health activities. This is but one phase of public health work. Heretofore it has been given grossly inadequate attention. In the field of infectious disease control it is the most urgent problem at the present time. Just as from time to time emphasis has been directed to typhoid, diphtheria, tuberculosis and other diseases, it is now being directed to venereal diseases.

CLINIC SERVICE

Next let us consider the problem of clinic service. About 25 per cent of those with venereal disease either cannot or will not pay for medical care. This group must be cared for in free clinics, or where no clinics are available, under some other arrangement.

It is fundamentally a health department function to see that treatment is provided for venereal disease patients. If free clinics meeting adequate standards are operated by county hospital or other agencies, there is no reason for health departments to duplicate this service. Health departments, however, are responsible for seeing that standards are maintained and that the epidemiological work is done in these clinics. As noted before, there are now about eighty clinics reporting to the state department. Some additional clinics in certain rural centers will have to be established and activities of many present clinics extended.

There are a few fundamental requirements that all clinics should meet. These were set forth in a report to clinics some time ago, and need not be given in detail here. The admission requirements, however, are worthy of reëmphasis. The following classes of patients should be admitted:

1. Any patient for initial diagnosis and emergency treatment if found infected.

2. Any patient referred by a private physician for consultation or special tests.

3. Any patient honestly unable to pay a private physician for treatment.

Residence requirements must be completely abolished. There are still a few clinics in the State that refuse to admit patients who cannot fulfill the local residence requirements. The fact that a patient is not a resident of three years' standing does not eliminate that patient as a public health menace.

We are prepared to assist clinics in the following ways:

1. We have prepared clinic record forms for issuance to any clinics desiring to use them.

2. We are rapidly working out plans for further assistance to clinics in the form of drugs, personnel or equipment, depending upon the need and the manifest desire to coöperate.

3. Clinics will be visited periodically and every effort made to assist them in the solution of their problems, medical as well as administrative.

The venereal disease control program of the local health department really centers about the clinic. Personnel from the health department should be in attendance at every clinic period to consult with the patients, check on missed treatments, to investigate contacts of clinic patients and attempt to find sources of infection. Health departments cannot reasonably expect county hospitals or other treatment agencies to relieve them of this work. We would recommend the establishment of a venereal disease registry in every health department. Specially trained nursing personnel will have to be added to a number of departments. We are working on plans for specialized training for this personnel.

INDIGENTS IN RURAL DISTRICTS

The provision of treatment for indigent patients in rural districts is a special problem. As soon as possible we hope to arrange to subsidize local physicians in these outlying districts for the care of these patients. Such cases will be investigated by personnel either from the local health department or from our own staff.

LABORATORY SERVICE

Adequate laboratory service is necessary. As a result of the wide publicity the load on private as well as public laboratories all over the State has markedly increased. Laboratory service for diagnosis must be available for all and, as with clinic service, free tests must be available for indigent patients. This will necessitate the extension of activity on the part of some local health departments.

A system of checking on state laboratories on a nation-wide basis has recently been developed by the United States Public Health Service. We plan to carry out the same general system on a state basis in California. The State Laboratory personnel is being sufficiently expanded to take care of this work.

THE HOPE OF THE PRESENT CAMPAIGN

The program in 1917 collapsed because it was built from the top down. It was more or less pushed onto the people by governmental agencies. The present program already has the support of the great mass of the people upon whose support the success of the movement essentially depends. It has the hearty endorsement and coöperation of the press, which was woefully lacking in 1917. With continued support progress in the control of these diseases can be effected.

The physician-health department relationship is not a one-sided affair. Health departments can be of definite assistance to physicians in the care of their venereal disease cases. We can assist them in keeping these cases under treatment. We can return their cases to treatment if lapses occur. We can render direct assistance to the physician by pro-

viding drugs. In return the physician can assist us by coöperating in the epidemiological work.

We believe that if we attack this phase of the problem tactfully, vigorously, and with sincerity of purpose, the physicians will rally to our support.

SUMMARY

1. Efforts are to be made to enlist the coöperation of physicians in reporting and in epidemiological investigation.

2. We are to endeavor to insure adequate clinic service by coöperation with and assistance to clinics. We may need to establish some new clinics.

3. Provisions are to be made for the care of indigent patients in rural districts.

4. Serodiagnostic laboratory service is to be standardized and, where necessary, extended.

5. Epidemiological work is to be markedly extended.

6. Free drugs for the treatment of syphilis are to be dispensed to physicians for the treatment of free and part-pay patients.

7. There is to be an active educational program for both the medical and nonmedical public.

8. The responsibility of local municipalities and health departments for the program in their districts is to be maintained.

A venereal disease control program is here to stay. With energetic control measures, continuously applied, we can expect results.

State Office Building,
McAllister and Larkin Streets.

THE LURE OF MEDICAL HISTORY†

WILLIAM WATT KERR

III*

By HERBERT C. MOFFITT, M.D.
San Francisco

THERE are few cities of the world so beautifully situated, few so interesting from wealth of history and tradition as Edinburgh—"Auld Reekie," or the "Athens of the North." It was there, in Newington Parish, July 27, 1857, that William Watt Kerr was born. The first well-known Ker, either of Newbattle or Temple parish, a few miles south of Edinburgh, was given only one "r" in his name, but during the next generation the other "r" was added, undoubtedly to afford the proper Scottish burr that *we* knew in Ker-r. He was a branch of the family known as the Kers of Ferniehirst, with the Marquis of Lothian as chief. James Kerr the second settled in Liberton, on the outskirts of town, about 1730, married Janet Johnstone, and had twin boys and a daughter. John, one of the twins, married Janet Rait and they had nine children; he married again, Anne Bethune Taylor, and they had two sons—Alan, who died in infancy, and Andrew, the father of Doctor Kerr. Andrew Kerr, born May 13, 1814, in the parish of Liberton, was a noted architect and an antiquarian of renown. By competitive examinations he became a member of Her Majesty's Board of Public Works, in charge of all public buildings of Scotland. The postoffice of Edinburgh, the fountain in front of Holyrood Palace, are mentioned as his work. He was a Fellow of the Royal Antiquarian Society and, on retiring from the Board of Works at sixty, devoted himself to antiquarian architecture, restoring Baron's Hall at Dawn Castle for the Earl of Moray, and Rosslyn Chapel for the Fourth Earl of Rosslyn, and was actively in demand for similar restorations until his death at the age of seventy-three. He was a burgess of Edinburgh, a member of the Merchant Company, one of the Holyrood constables, well liked, well known as a good talker and raconteur—gifts which he transmitted to his sons. On December 18, 1840, he married Grace Watt, the daughter of James and Janet Watt, by whom he had nine children: John, Janet, James, Andrew, David, Annie, Euphemia, William, and Robert. By all accounts Janet MacAlpine, the doctor's grandmother, was a remarkable, forceful, intellectual matriarch, who knew what she wanted, and usually got it. The laird had proposed for her hand, and had strong backing from her parents. The parents argued, Janet objected, the laird agreed to wait, but a friendly minister was found; a sister snooping—as sisters will—discovered a marriage certificate in the names of James and Janet, and the fat was in the fire. The marriage was perfectly legal and could not be undone; but the culprits were brought before the Kirk Session, a strict and sour assemblage in those days. They were both children of elders of the Kirk, iniquity in such high places must be sternly dealt with, and a double fine was levied. But "Na, Na," said the bridegroom, "come awa, Jenny," and left the elders to rattle the few coins of a single fine.

Doctor Kerr's mother died on April 17, 1900, and is buried in Grange Cathedral with her husband. The memory of a daughter, Phemie, then seventy-one, is given of her in a letter written to James Kerr in September, 1926: "To describe her would be just impossible. She certainly, for more than four score years, had wrought for others, soothed the hurt of tears, rocked children's cradles, eased the fever's smart, dropped balm of love in many an aching heart, and father never would have been the man he was had she not been his life's companion."

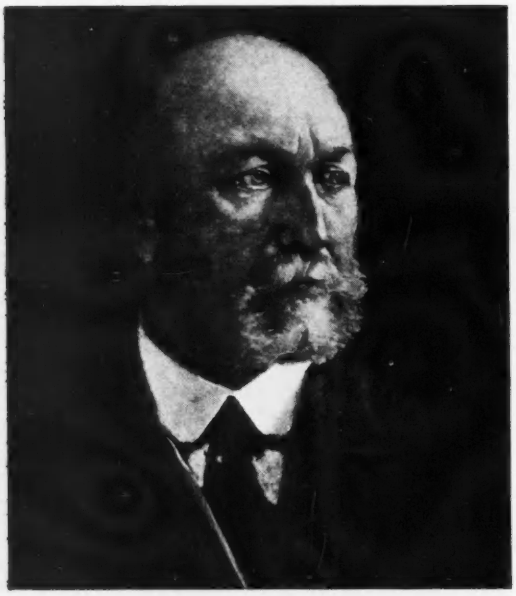
UNDERGRADUATE DAYS

From the Royal High School William Watt Kerr entered the University of Edinburgh, was graduated in April, 1876, and passed his examinations in medicine in the spring of 1881, with the degrees A.M., M.B., C.M. We know that he played football at the University, but unfortunately little more. We know, however, that, in his time, interesting characters were to be seen strolling through the meadows near the Royal Infirmary, or climbing the hilly streets between the high-piled buildings of the town. John Stuart Blackie (whom we learn

†A Twenty-Five Years Ago column, made up of excerpts from the official journal of the California Medical Association of twenty-five years ago, is printed in each issue of CALIFORNIA AND WESTERN MEDICINE. The column is one of the regular features of the Miscellany department, and its page number will be found on the front cover.

*One of the papers given in Toland Hall, University of California Medical School, San Francisco, in the series on the history of the institution, arranged by the Division of the History of Medicine.

This is Paper III of the series. For other articles in the symposium, see CALIFORNIA AND WESTERN MEDICINE, November, 1937, page 321; December, page 405.



WILLIAM WATT KERR, A.M., M.B., C.M.
1887–1889—Professor of Therapeutics
1889–1917—Clinical Professor of Medicine
University of California Medical School

of from "Christopher North"), the great teacher of Greek and the humanities, the prototype of the absent-minded professor, could be seen stalking about the city with his famous plaid over his shoulders. Passing the consulting rooms of a noted surgeon one day, he went in to have a sudden, pronounced limp investigated. It was found that he had been walking with one foot on the curb, the other in the gutter—hence the limp. Probably Sir William Turner, professor of anatomy and noted anthropologist, was dissecting his famous high-powered seventy-foot whale in the quadrangle about this time, which got him into decidedly bad odor with the townfolk. And Doctor Kerr may have attended the lectures of Alexander Crum Brown, professor of chemistry and a great character and scholar—a series on the "Alphabet" which lasted through the year and never got beyond the letter "C." During these years Joseph Bell was attracting crowds of students to his extramural lectures, wholly unaware that he was sitting for the portrait of the famous Sherlock Holmes, for Conan Doyle was then at the University, awaiting graduation as M. B. in 1881, and M. D. in 1885. Stirring events were shaping history at the Royal Infirmary during Doctor Kerr's time. Fifteen hundred students were attending lectures in medicine. In the surgical building, Lister, who returned to Edinburgh in 1869, was demonstrating his epochal discoveries, his meticulous care of antisepsis and of dressings, until he went to London in 1877. The new buildings of the University were completed in 1879, and "Farewell to the old Infirmary!" was sung with "Auld Lang Syne" by the resident staff in October of that year. Perhaps an inspiration for Doctor McNutt's poem of farewell to the old Toland school just twenty years later!

LURE OF CALIFORNIA

Doctor Kerr left Edinburgh in 1881 with inheritance of health, pride of family, *noblesse oblige,* and the highest principles; with traditions of a great University behind him, with the inspiring new medical teaching at his command. Fortunately for us, his uncles, William and Robert Watt, had been in California for years and had risen to be chief owners of the famous old Eureka mine in Grass Valley, and this affected the doctor's decision to come to the Pacific Coast. His brother, James Watt Kerr, eleven years older, a noted mining engineer, had arrived in 1867 to take charge of the mine, had moved to San Francisco in 1874, when the Colmans assumed control, and had started manufacturing mining machinery. Mr. Kerr was an interesting man whom many of us knew—impressive, forceful, uncompromising in his strict interpretation of business integrity. His strong stand in several big San Francisco strikes is well remembered. For several years Doctor Kerr made his home with his brother on Octavia Street, and it was there that he met Miss Rowena Boobar, whom he married in 1886. All know the happiness that each succeeding year brought in greater measure to both. Mrs. Kerr lived but to anticipate the doctor's needs and wishes; when she saw him anxious, tired, not in his usual harmony with the world, she would suggest a dinner with his old cronies—chief among them, Swan, Lewitt, Wadsworth, and von Hoffman. Straightway his face would beam and planning of the menu began. Mrs. Kerr died of heart disease on December 23, 1934.

EARLY DAYS IN SAN FRANCISCO

With the triumphs of Listerism fresh in mind, Doctor Kerr at first intended to do mainly surgery. He became associated, however, with Dr. James Simpson, a relative by marriage of his brother, and gradually took over both the office and outside medical practice. Doctor Simpson had prospered in various mining towns in California, and had moved to San Francisco in 1872, where he continued his success. He was professor of materia medica and therapeutics for four years at Toland from 1879 to 1883. Henry Harris has characterized him as "a rare, sound uplifter, devoid of killjoy, a sophisticated and recurring sampler of straight or mixed beverages." This association, and his growing reputation as an authority on diseases of the chest, determined once and for all Doctor Kerr's future bent, and he gave away his surgical instruments. But for many years he practiced obstetrics, which had been so ably taught in Edinburgh by Sir Alex Russell Simpson, of whom he often spoke. He always liked the specialty, was extremely good at it, and only gave it up when warnings of his circulatory limitations no longer could be ignored. He was a sworn foe of the abominable "formulas" so often forced down infants' throats, and was always seeking substantial if not highly moral wet nurses. Those of us who remember Jimmy, his driver for many years, who sat in the hall during office hours after the doctor moved from 522 and later 600 Sutter Street, will recall the arguments with Nellie, who ushered in

the patients, as to shunting of portly ladies into the private or the supply departments.

INTEREST IN ORGANIZED MEDICINE

Despite his youth, practice grew rapidly, and he was active in many other ways. As early as 1882 his name appears as a member of the State Medical Society in the published volume of transactions. During the next years he was a member and later chairman of the Board of Censors, a member of committees on public health, clinical medicine, microscopy, and in 1887 rendered a report as chairman of the Committee on the Practice of Medicine. It would be interesting, at some future date, to quote longer excerpts from this report, from his address as president of the State Society and from his various papers on the heart. In the report of 1887 he said: "Perhaps the most distinctive feature in medical thought at the present time is the tendency to adopt a local treatment instead of internal medication. What may be regarded as minor surgery is becoming more common among physicians, while under their advice new and graver operations are undertaken for which the skill of the specialist in this department is required. Indeed, so aggressive has surgery become that it is frequently impossible to decide to which department the cases belong, and it is absolutely necessary for the physician to understand the risks and responsibilities of each operation, since with him lies the responsibility of recommending it at an early stage or temporizing."

CHAIRS IN THE MEDICAL SCHOOL

Some time in 1885 and 1886 he is reported to have worked with Doctor James Blake on the pharmacology of cerium salts; and on June 12, 1886, the faculty of Cooper Medical College passed resolutions thanking him for a course of lectures on hygiene, which he had delivered during the winter semester of 1885. On December 27, 1886, he was appointed professor of therapeutics in the Medical School of the University of California, resigning January 8, 1889, to become professor of clinical medicine, a position he held until his death, April 26, 1917. Even while in charge of therapeutics he had been teaching medicine in the wards under Doctor Kane, whom he succeeded.

A BUSY LIFE

And now, until the earthquake and fire, followed tremendous years, though made up largely of horse-and-buggy days. He was increasingly in demand as a consultant, as well as a family physician. Visits before his eight o'clock lectures, fifteen to twenty more during the morning, still others after office hours, kept Jimmy and two teams circulating rapidly all over town. He was always particularly interested in diseases of the circulatory system, but covered the field of general medicine in his practice as in his lectures. He was a keen observer, a master of percussion, auscultation and palpation. Despite early contact with the model of Sherlock Holmes, he always warned against snap diagnoses. And yet, as Doctor von Adelung has recently written me, "Doctor Kerr possessed what is sometimes called the sixth sense in medicine, the diagnostic 'hunch,' which is not a hunch but wisdom acquired by long, close study and careful observation." He was much impressed with Jonathan Hutchinson's little book on "The Pedigree of Disease," which appeared in 1886. With him the proper order of procedure was careful examination, individualization, consideration of constitution, temperament and idiosyncrasies, and finally prescribing. As the conclusion of his report on medicine to the State Society in 1887, he wrote: "In the treatment of disease the physician should endeavor to have the normal and perverted physiological processes in each individual case as clearly before his mind as the surgeon has the arteries, veins, and nerves that he is to avoid in the performance of some operation." Again: "There is too much 'book' medicine at present, too great a tendency to regard the sick as something closely akin to a vessel containing certain noxious ingredients which are neutralized by the additions of certain antidotes; and too strong an inclination to look upon the patient as a machine out of repair, instead of a living being in whom vital and chemical changes are taking place that must more or less interfere with our remedies." In later years he used comparatively few drugs, but had faith in digitalis, arsenic iodids, bromids, and opium. It is interesting to glance through old files of Lengfeld's Pharmacy, kindly furnished by the managers of the Shumate stores, and to find his small, neatly written prescriptions, signed "Wm. Watt Kerr," calling for his old favorites, Murchisan's pills or codein with syrup of tolu. A lesson in prescribing promiscuously was taught him, he told Doctor Woolsey, by one of his early patients. He had been assiduous in attending a maiden lady, frequently changing medicines during six or eight months. Finally, he told her his services were no longer needed, as she had completely recovered. She spoke of the great value of the many remedies, and he felt duly complimented. She then raised the two pillows of her bed and underneath, marshalled in imposing rows, were the many bottles, all *unopened*. That one lesson was enough! He was a clinician of the Edinburgh school, broadening, advancing each year by reading, teaching and experience with all kinds of diseases, all types of men, yet always ready to make use of new methods, new instruments in diagnosis; always eager to test new remedies, to profit by surgical advances. He, as well as Doctor Hirschfelder, experimented with tuberculin at the County Hospital in 1891. The Widal reaction was tried in his wards soon after it was described in 1896. He encouraged Doctor Ryfkogel in his clinical laboratory work, and stood stalwartly behind him and the courageous Board of Health when attacked by governor, big business, and a group of subservient doctors during the plague scandal of 1900.

GEORGE WILLIAMS HOOPER FOUNDATION

From student days, Doctor Kerr was familiar with the publications of Gull and Ord on myxedema. He had no difficulty, therefore, in recognizing a typical picture of the disease in Mr. George Williams Hooper, who consulted him soon after

the appearance of Murray's report of four cases treated successfully by juice expressed from thyroid glands of sheep. Mr. Hooper changed marvelously for the better soon after starting treatment, and daily thereafter sent to the slaughterhouses for fresh sheep thyroids. Somewhat later Doctor Kerr took Mr. Hooper to Doctor Starr of Philadelphia, who concurred in the diagnosis and suggested a trial of desiccated thyroid, which had been introduced in tablet form by the Parke Davis Company in 1893, one year after publication of Murray's paper. It is interesting to note that Mr. Hooper took twenty grains daily for many months, later only five grains of the Burroughs Wellcome preparation, and that in his last years only one-fifth grain, as any larger dose promptly caused disagreeable symptoms. To Mr. Hooper's interest in scientific and experimental medicine, aroused by Doctor Kerr, kept active by Doctor Ebright, we owe the George Williams Hooper Foundation.

DOCTOR KERR'S PERSONALITY

In a recent address before the Edinburgh Royal Medical Society—the oldest association of medical students in Great Britain—Lord Horder used words that could well have been applied to Doctor Kerr: "For the doctor there can be no left or right; for him there is expert knowledge and a rooted adherence to truth and horse sense." Patients were drawn to Doctor Kerr by his stalwart presence and winning personality; they loved him for his gentleness and kindness, and had confidence in his knowledge, his stability, his voice, even the creaking of his shoes as he climbed the stairs to the sickroom. They knew instinctively that he was honest, straightforward, dependable. No doctor ever had more loyal followers.

HIS RÔLE IN THE MEDICAL SCHOOL OF THE UNIVERSITY

Who can speak adequately of his thirty years devoted to teaching in the University of California? His soul was in his work, his heart was given to his students. Turn back the pages of the old announcements to 1887: "Professor Kerr will direct the attention of the student to general medical diseases, exercise him in physical and differential diagnosis, and give him every opportunity of putting into practice the knowledge he has acquired from his didactic lectures." Moreover, there was to be "instruction in all these details which qualify the student to discharge his duty agreeably and efficiently in the sickroom." Lovely language, but certainly *not* that of Doctor Kerr. Whose *was* the mysterious voice that echoed through the old announcements? Three times a week, Tuesdays, Thursdays, Saturdays, the clock struck eight as he entered the amphitheater. The black skull cap was taken from his pocket, unfolded, and usually donned. Standing, walking about, in later years sitting in his chair, he spoke easily, simply, of the disease in question, or demonstrated its characteristic features in patients brought from his wards. There was no drama, there were no frills, but the students felt that what he said was *so*. He aimed to cover the whole field of medicine in the course of lectures to the third and fourth years. It is interesting to see from these lists of diseases considered during the year that syphilis, tuberculosis, exanthemata, and other infections were kept in integral part of the department of medicine—where they still belong. Typhoid, cerebrospinal fever, and thirty-one cases of malaria are recorded in one year at the hospital, and 3,641 visits to the old clinic on New Montgomery Street. Only one man of this 3,641—so different from now—could be called a pay patient, and he came because he swallowed a five-dollar gold piece. Thanks to our present beneficent government, this could not happen here.

THE OLD CITY AND COUNTY HOSPITAL OF SAN FRANCISCO

The old City and County Hospital was erected in 1873. It was a great old place, full of memories that did not all go up in the smoke of its destruction. The site was well chosen, and we can vouch for the salubrious, stimulating Mission climate, for in 1899 six guinea pigs were presented to Doctor Ebright, and by the time of transference to Ingleside, there were at least two thousand. After August, 1907, when a case of bubonic plague was found, no new cases were admitted, and on January 2, 1908, the 130 patients remaining were transferred to a building on the Alms House Tract. On March 10, 1908, a fire broke out in this old four-story wooden building—fortunately, about eight in the morning—and all inmates were saved. Patients were then housed in the Alms House Building No. 1, and on April 10, 1908, were moved to the stables of the Ingleside Race Track. In the summer of 1909 the first reinforced concrete building erected in the city was completed on the Alms House Tract; habitués of the track were transferred and remained there until May, 1915, when the magnificent new San Francisco Hospital was opened. Picture the old county wards!—thirty-two beds, covered with the faded checkered pink, only to be duplicated on old-time restaurant tables; *Nachtische,* commodes or storage vans of the old ladies crammed with old shoes, hair switches, and paper bags of goodies; the old women, *full* of complaints, which faded to whispers at Doctor Kerr's approach, for his heartiness never failed to win a smile from even the most obstreperous virago. Through these wards walked with him students and internes, whose later careers were shaped as much by his example as by his teaching. It was my good luck to be welcomed by him here in 1898, my misfortune, soon after, to have a so-called promotion transfer me to Parnassus Heights. Those of you fortunate enough to have been his internes will recall his kindness, his justness, his square-dealing with alcoholic and other peccadillos. Would that we had time to recount his stories, to tell of his clinical acumen and keen use of all his senses. Passing one day the open door of one of the rooms for contagious diseases he paused, sniffed, and asked what case was there. "A case on the P and S service, hemorrhagic measles," replied the interne. "Better tell them to quarantine for smallpox," said Doctor Kerr, and so the case proved to be. Then, as now, patients with undesirable infections, with

finances running low, were transferred to the county from other hospitals. Two well-spotted patients were sent over from St. Luke's as suspected typhus. Doctor Kerr pronounced them typhoid; the Widal reaction, done almost for the first time by Ryfkogel and Ebright, said likewise. Giannini, who had volunteered to take care of them, was firmly persuaded that they and he, *too*, had typhus; but the autopsy proved typhoid, and Giannini recovered.

HIS CONTRIBUTIONS TO MEDICAL LITERATURE

Though swamped with practice, meticulous in care of teaching and hospital service, Doctor Kerr found time for writing and medical society activities. A list of his papers was published by J. Homer Woolsey in CALIFORNIA AND WESTERN MEDICINE (Vol. 23, p. 607). Of the thirty-four articles, seventeen dealt with diseases of the circulatory system. These were always interesting to him, and soon after arriving in San Francisco he wrote a long paper on functions of the capillaries, and in January, 1889, he reported two cases of aneurysm treated by wiring and electrolysis in October and December, 1887. His papers on myocardial insufficiency, angina pectoris, angina sine dolore, on the value of arsenic, iodids, protiodid of mercury in chronic heart disease, on the danger of hot baths in arteriosclerosis, on the necessity of caution in giving nitrites in angina pectoris, are full of valuable observations and suggestions that are well worth reviewing today. He emphasized the value of hyperesthesia in distribution of the left intercostohumeral nerve as a precursor of angina pectoris, was in favor of abandoning the vague term "pseudo-angina," spoke often in aphorisms or maxims, such as "Football men take more risks on bones and neck, but sprinters and hurdlers more on heart." Early descriptions of eosinophilia in trichiniasis, of typhoid meningitis, and a timely lecture on plague, showed his interest in application of laboratory methods to clinical medicine.

MEDICAL SOCIETY ACTIVITIES

He was president of the San Francisco Medical Society (1893-1894); president of the Academy of Medicine; president of the State Medical Society in 1898-1899. Those knowing only the amenities of golf, teas, and ladies auxiliaries of our emasculated meetings, can scarcely understand the vigorous language, picture the strenuous doings of the doctors of the eighties or nineties. Old warriors can still hear the thunder of C. P. Buckley against oxytuberculin and the plague, the queer but vehement English of Charles G. Kuhlmann, "I will once more iterate and demonstrate that bacteriological investigations are of no value in elucidating the causes of disease." We still see the fiery MacMonagle, the suave Tait rising to compliment the speaker and to annihilate him by quotations from the French. Some of us thought the earth trembled on the morning of April 18, 1906; it was but the reverberation of forces that shook it during three days of a state medical meeting in April, 1898. Doctor Pedlar of Fresno, in welcoming the State Society, uttered most high-minded sentiments: "We, the great army of busy physicians, come together as a fraternal body, and it is our duty to foster a fraternal spirit." Next day Doctor Kerr was nominated for the presidency by W. L. Wills of Los Angeles, and Washington Ayer proposed the name of Doctor McNutt, who, it was rumored, had written touching letters to the country practitioners and rather packed the court. In seconding the nomination of Doctor Kerr, Doctor MacMonagle made use of certain expressions and evidently forgot to smile. He was encountered later on the floor and charged by Doctor Potter, who, advancing his topper like a shield with his left, wielded his umbrella like a saber with his right. It is not uninstructive to read an account of the election: "As the votes progressed, the excitement became intense, and not until the last vote was counted could the result be foreseen. When, however, the smoke cleared away and the chair announced the vote as Kerr 48, McNutt 47, pandemonium reigned supreme, and the chair announced the election of Doctor Kerr by one vote, thus overlooking members who were calling for a recount." In an editorial in the journal of the rival faction (Doctors McNutt, Potter, Winslow Anderson, and others) it is stated plainly that "Doctor Kerr was not present, and it is believed would not have countenanced the methods had he been there." "To understand Doctor MacMonagle's intense excitement we have only to say that twice he called Doctor Potter 'Doctor Plummer,' and to understand Doctor Potter's extreme forbearance we have only to say that he stood this without resentment." Ready fists but *toujours la politesse* in those days! Some of you may remember the rather dubious congratulations of Doctor McNutt to the Medical School on moving from Toland to the Parnassus site: "In its new quarters, undisturbed by the chirp of the cricket and the souffle of the pines, the student can study nature in all her naturalness, free from clinics and dispensaries."

OSLER'S "DOCTOR'S DISEASE"

There is a disease, insidiously, often silently, undermining in its early stages, that too often strikes down men of our profession in their prime. Osler has called it the doctor's disease. Recent statistics of H. L. Smith, from the Mayo Clinic, emphasize again that its incidence is four times greater in physicians than in laborers or farmers, twice greater than in bankers, ministers, or lawyers. It has recently taken a great friend and doctor from our ranks. Doctor Kerr was singularly free of minor ills, although he had heard "the lispings of the gout" and experienced an attack of renal colic. On October 3, 1904, he had been catapulted from his autocar to the pavement, with resultant injuries to head and left shoulder that incapacitated him for four months, but fortunately left no permanent damage. Then, about 1910, he would frequently have to pause in corridors or wards because of claudication of the left leg. Later came an annoying sense of cold about the precordium and, still later, typical angina on exertion. Attacks came with slighter cause and with increasing pain. They did not ruffle his calm equanimity. Cheerfully he

put his house in order, and Mrs. Kerr and he never faltered on their path of duty. He studied, with curious intentness, the varied manifestations of advancing vascular changes. He published, one of several similar papers, "Notes on Angina Pectoris" in the State Journal in 1915, and a remarkable account of experiments on himself in an article entitled "Danger of Hot Baths in Patients Suffering from Arteriosclerosis" in the State Journal of 1916. He was seen in January, 1916, with his physician three days after an attack of coronary thrombosis. Even then he could not be persuaded to give up the work, the teaching he loved so well. Outwardly there was little change; but the year went by with increasing effort, and in March of 1917 he gave his last lecture, which has been dramatically described by one of the men present. Students waiting in the corridor saw him walk slowly from his car. Seating himself in the amphitheater, he paused longer than the customary time, glanced over the rows before him, and said, slowly: "We shall speak today of angina pectoris. Not of the pathology, which is familiar to you all, nor of the slighter pains which grip the chest and spread to arms—right as well as left—but of sensations that can less well be put in words. There comes a moment when the heart seems all too small to overcome the great pressure gathering in the chest. A massive column of blood seems surging upward and to the left and can find no outlet in passages that feel too rigid. And, rising from the chest, a constricting force grasps the throat and squeezes upward to the angles of the jaw." Students who heard him have never forgotten the hour—they saw him then for the last time. Soon after two o'clock on the afternoon of April 26, 1917, his nephew, Andrew Kerr, was seated in his waiting room in the Galen Building. C. C. Moore, an old friend and patient of the doctor, had just entered the consulting room, when he rushed back crying, "Something has happened to the doctor!" Doctor Kerr had risen from the desk to greet him, but had sunk back silently into his chair. When several of us got there a few minutes later, he had been laid upon a couch, on his face no sign of suffering. Doctor Kerr was dead.

A GREAT TEACHER, A GREAT PHYSICIAN, A GREAT MAN

His portrait and photographs speak eloquently of the Doctor Kerr we knew. We see there strength, honesty, kindliness, dignity. No wonder he was honored, revered, and loved. To his students he was always "Daddy Kerr." Deeply religious, but without parade, he was a good citizen, a loyal friend, a lover of his native and his adopted lands. Grave and conscientious at his work, but full of the joy of living, he was a boy again on his fishing trips and vacations; a genial host, whose beaming face and hearty laugh drove care away. Few things could ruffle his even temper, but righteous indignation was always roused by shams and lies, and fanatical attacks on scientific medicine. His memory will live as a great teacher, a great physician, a great *man*.

384 Post Street.

CLINICAL NOTES AND CASE REPORTS

MULTIPLE CONGENITAL ABNORMALITIES*

By N. Berwyn Lawrence, M.D.
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AND
E. Harold Shryock, M.D.
Loma Linda

WE present herewith a case of congenital malformation in which there were so many separate deformities, and some of the deformities were so extreme, that we feel the report may be worthy of publication.

REPORT OF CASE

The case was that of a fetus which had undergone about thirty-two to thirty-four weeks of development. It was delivered in the home on November 21, 1936, by Doctor Lawrence. The family consisted of a father and a mother, each aged 26, and two healthy children, aged, respectively, four and six. Both parents responded negatively to the Wassermann reaction, and there was no history of abortions or miscarriages, nor was there any history of congenital malformations among the known relatives, except that one child in the immediate family has a small cervical cyst.

Aside from the delivery being somewhat premature, the first observation of note at the time was that the presentation seemed to be that of the breech. Vaginal examination appeared to confirm the idea of a breech presentation, but indicated that there was no true gluteal cleft, thus making the operator suspicious of an imperforate anus. The usual amount of amniotic fluid was apparent at the delivery.

External Deformities.—At the completion of delivery the following externally apparent deformities became evident: imperforate anus, absence of left lower extremity below the knee joint, the left hand consisted of but two digits (the thumb and first finger), webbed left elbow (left forearm could not be extended), right talipes varus, absence of penis, and absence of the urethral orifice.

The child breathed a few times, tried to cry, and then spontaneously ceased to breathe.

X-Ray Studies.—Before performing an autopsy the accompanying photographs were taken and a complete x-ray study was made by Dr. Elizabeth J. Hiscox, roentgenologist at the Loma Linda Sanitarium. The x-ray studies indicated an absence of all the bones of the left leg (the patella was present and just beginning to ossify), absence of the left ulna, absence of those metacarpal bones and phalanges corresponding to the absent medial three digits of the left hand (the carpal bones, as yet, showed no ossification), a typical talipes varus on the right, and an incomplete development (approaching an absence) of the sacrum and coccyx.

Autopsy.—The autopsy was performed by Dr. Oran I. Cutler, Professor of Pathology at the College of Medical Evangelists. It revealed that the lungs had never been inflated, but that, due to a tracheo-esophageal fistula, the stomach had been filled with air at the time the child took a few breaths. Also, the right lung consisted of but a single lobe. There was a small accessory spleen, no gall bladder could be found, and the large bowel terminated abruptly at a point corresponding to the junction of the sigmoid and rectum. The testes had not completed their descent, one being found in an inguinal canal and the other within the pelvic cavity. Although the suprarenal glands were present, there was, grossly, an entire absence of both kidneys, both ureters, the bladder, and the urethra. There was observed a small duct extending between the umbilical aperture and the blind ending of the large bowel. This was interpreted

* From the Department of Microscopic Anatomy, College of Medical Evangelists, Loma Linda.

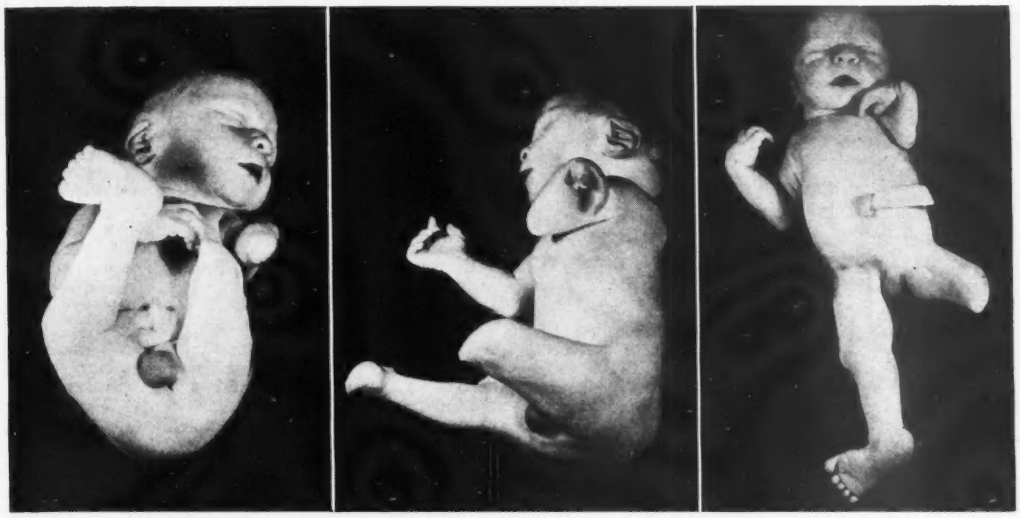

Fig. 1 Fig. 2 Fig. 3

Fig. 1.—Complete absence of anal opening and gluteal cleft.

Fig. 2.—Amputation of lower left limb just below the knee joint. Web formation between left arm and forearm, and showing presence of only left thumb and index finger.

Fig. 3.—Showing absence of penis, and right club foot.

to be the urachus. The skull was not opened, but no deformities of the head were externally apparent.

Microscopic Findings.—A section taken from the wall of the urachus revealed, upon microscopic examination, some fragments of transitional epithelium. Sections were also taken from a small multicystic structure found just below the left suprarenal gland. These showed many small epithelial lined structures which, it was thought, might be rudimentary kidney tubules.

COMMENT

Perhaps the most striking anomaly present in this case was the absence of the urinary system. Not only would this seem to indicate that the kidneys of a fetus are not necessarily active during even the latter months of intra-uterine life, but it would seem to furnish conclusive evidence against

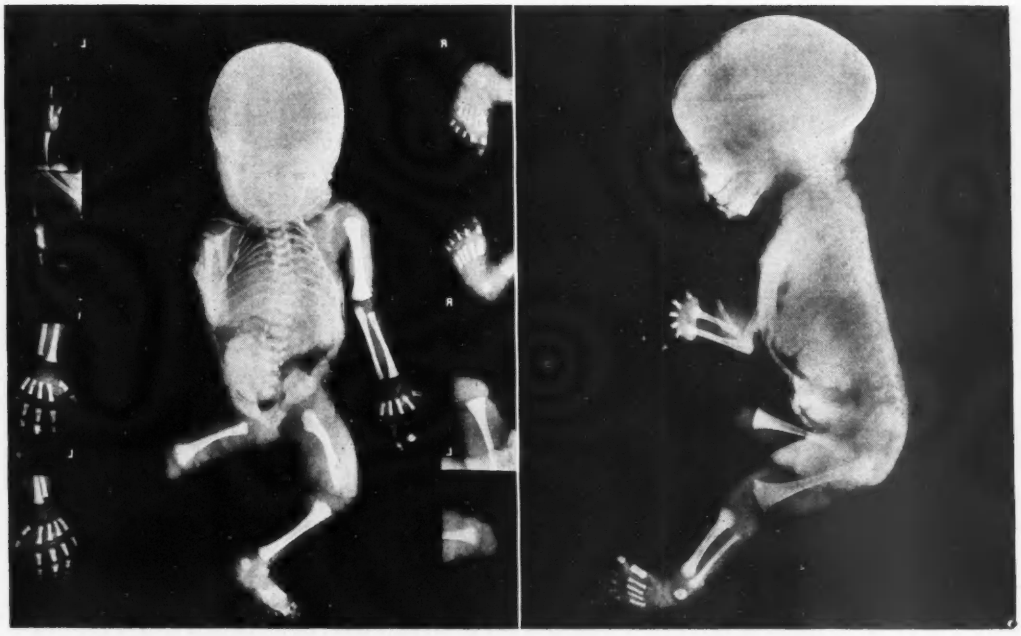

Fig. 4 Fig. 5

Fig. 4.—Various views of the bony abnormalities, as well as of entire fetus, viewed posteriorly.

Fig. 5.—Lateral view of infant showing ossification centers in proximal end left tibia, and complete absence of ulna in left forearm.

the old theory that the amniotic fluid is the product of the fetal kidneys; for, in this case, in spite of the absence of even a urethral orifice, there was a normal amount of amniotic fluid present.

The tracheo-esophageal fistula was evidently the immediate cause of death. Had it not been for this deformity, either the absence of the urinary system or the absence of the rectum with the associated imperforate anus would, of course, have produced death within a relatively few hours. The other deformities found would, presumably, have been consistent with life.

The only clew as to the possible cause of the many deformities exhibited in this case is the admission by the parents of the use of a chemical contraceptive prior to conception. Whether or not we are justified in assuming that, under such circumstances, injury to the germ cells may result in congenital deformities, is problematical.

SUMMARY

The case presented is that of a fetus of about thirty-two to thirty-four weeks of development, in which approximately eighteen single deformities were noted. Included in this list of deformities are the virtual absences of all of the essential parts of the urinary system.

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IODODERMA DUE TO LIPIODOL*

By SAUL S. ROBINSON, M.D.
Los Angeles

THE injection of iodized oil in the form of lipiodol has been employed since 1922 for bronchography and other diagnostic procedures.[1] In 1927, Belote[2] of the University of Michigan reported the first case of iododerma following a lipiodol injection. O'Donovan,[3] Carmichael[4] (two cases), Scadding[5] (two cases), and Goldstein[6] have since recorded six additional cases of iododerma following the injection of iodized oil. There have been no case reports from California. Two of the reported cases have been fatal and indicate the severe idiosyncrasy that a patient may show to lipiodol. A fatal issue may depend on the combination of a marked iodin idiosyncrasy and the large amount of iodized oil usually injected for diagnostic purposes (20 cubic centimeters). Because of the widespread use of lipiodol and the severity of the iododerma that may result from its administration, the following case report is considered of interest.

REPORT OF CASE

Mr. H. K., aged 60, consulted me on May 13, 1937, because of an eruption that had appeared on the previous day over the trunk, the neck, and the extremities. No subjective symptoms were associated with the skin lesions. The past history revealed that the patient had suffered from a cardiac and a bronchial disorder, and on April 26 he had been given an intratracheal injection of 20 cubic centimeters of lipiodol for bronchography. The patient had been in good health since the injection, but complained of a disagreeable taste, probably due to the coughing up of the iodized oil. The only medication taken internally had been theominal for cardiac pain.

The dermatologic examination revealed a discrete, erythematous, pinhead to pea-sized maculopapular eruption located on the chest, back, neck, upper extremities, and the thighs. No lesions were present on the mucous membranes of the mouth and the throat. No adenopathy was present. The Wassermann and Kahn reactions on the blood serum were negative. The urine showed a strongly positive test for the presence of iodin.

The dermatologic diagnosis was iododerma following an intratracheal injection of lipiodol. Enteric-coated sodium chlorid tablets in the doseage of 15½ grains three times daily were given, with rapid clearing of the eruption. The theominal was administered with no effect on the eruption.

COMMENT

The elimination of iodin from the body after an intratracheal lipiodol injection is effected mechanically and by absorption through the usual body channels. Mechanical elimination of the iodin occurs by coughing up and expectorating the iodized oil. Moeller and Von Magnus[7] found iodin present in the urine as early as six hours following a lipiodol injection. These investigators reported the peak of urinary iodin excretion to occur in twenty-four hours, with iodin absent after six days. Iglauer[8] also reported the absence of iodin in the urine after six days, with the presence of iodized oil in the lungs for many weeks after the injection. It is interesting to note, in view of the above findings, that my patient's urine contained iodin eighteen days after the lipiodol administration. This delayed iodin excretion may account for the delayed appearance of the iododerma in my case.

The infrequency of severe iodism and iododerma following lipiodol injection is probably due to the stable chemical combination of the iodin and the unsaturated fats in lipiodol. Lipiodol consists of a 40 per cent solution of mettaloid iodin in neutral poppy-seed oil. Cases of iododerma from iodized oil have been reported where the patients had received iodin previously in other forms such as potassium iodid without manifesting idiosyncrasies to the drug, but developing iododerma after a lipiodol injection. Inasmuch as severe iododermas may occur from lipiodol, it is unfortunate that there is no method of determining iodin idiosyncrasy in patients before the lipiodol administration.

1930 Wilshire Boulevard.

* From the Department of Dermatology, Cedars of Lebanon Hospital, Los Angeles.

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BEDSIDE MEDICINE FOR BEDSIDE DOCTORS

An Open Forum for brief discussions of the workaday problems of the bedside doctor. Suggestions of subjects for discussions invited.

SURGERY AND SYPHILIS

I. SYPHILIS IN RELATION TO GENERAL SURGERY

CHARLES EATON PHILLIPS, M. D. (2007 Wilshire Boulevard, Los Angeles).—The incidence of syphilis can only be estimated, as there are no statistics available to show its extent. The American Social Hygiene Association estimate that 5 per cent of the population are syphilitic. Such an estimate, from that source, is probably essentially correct.

Many diseases, such as smallpox, yellow fever, plague, puerperal fever, malaria, tuberculosis, and others, destroy a greater percentage of those infected, yet their deadliness is recognized and feared, and their ravages have been stopped by scientific medicine. Our knowledge concerning syphilis, its cause, course, symptoms, and methods of relief and cure, are as comprehensive as our understanding of any of the other deadly diseases, and yet we have not checked its ravages to any extent.

Destructive Action of Syphilis.—It still stands in the front rank of diseases destroying the race. There are reasons for this condition. First, let us list the difficulties of detection. A person may be suffering from syphilis in a contagious form, and still not show any characteristic symptoms which would warn those who might come in contact with him. Syphilis may be transferred before the symptoms of the disease become manifested. It may be contracted, and the person may not be aware of the infection until long afterward, when the disease is firmly established and a cure impossible.

The second reason for the spread of syphilis is that a little treatment will frequently clear up the early symptoms, and the patient goes on (ignorantly or carelessly) spreading infection. Many times the syphilitic patient receives treatment before a definite diagnosis is made. Neither the doctor nor the patient knows what the patient has, and as soon as the symptoms are relieved the treatment is stopped and the patient eventually dies of syphilis.

The fallacy that the infection can be stopped by an early cauterization of the initial sore is responsible for many cases which could be cured by adequate treatment in the early stage of the disease. It has been shown, since the discovery of the treponema, that the infection becomes widely diffused in the body almost from the first, and any kind of local treatment is entirely unavailing in an attempt to stop the disease before it becomes systemic.

Many initial sores are overlooked or, if seen, are not recognized. The difference between the number of those known syphilitic and the number who show the presence of the infection by its late manifestations, illustrate the dangers of overlooking syphilitic infection.

In 1924, Newsholme estimated that the annual death rate from known syphilis was one hundred and eighteen per million, or a total of about four thousand in England and Wales.

Osler (1915) estimated, in the same geographic limits, that the effects of syphilitic infection, neurologic, and cardiovascular were responsible for sixty thousand deaths, or fifteen times as many as were recognized as syphilitics. When we add to this number the sterilities, abortions, miscarriages and, worse than all, the mentally and physically unfit due to syphilitic infections, then we can see the appalling destruction that is due to syphilitic infection, and how it occupies a position as the most destructive disease affecting the human race.

In the Johns Hopkins Hospital Medical Service, where the Wassermann test is obligatory on every patient admitted, syphilis appears in 20 to 25 per cent of all colored patients, and from 7 to 10 per cent of the whites. One would expect the incidence of the disease to be considerably higher on the medical service than on the surgical side; yet the number of unsuspected cases that appear shows the necessity of continual vigilance in every department of medicine and surgery.

According to Albert Keidel, life insurance data show that among insured syphilitics there is a mortality of 168, compared with a rate of 100 covering all classes of insured persons, including the syphilitics. The same author states that 25 per cent of patients with recognized but untreated syphilis of more than two years' duration will have central nervous system involvement, and that from 40 to 80 per cent of such cases will have cardiovascular damage sufficient to lower their reserve.

Surgery in syphilitics is attended with an element of uncertainty. Active, untreated syphilis contraindicates all except absolutely emergency surgery. The syphilitic with infection under control offers no particular problem to the surgeon, and but slight increase in risk. Patients with latent untreated syphilis show a rate of danger distinctly higher than that in uninfected cases.

Danger of Syphilis in Surgery.—Syphilis offers a threefold danger in surgery:

First, it leads to errors in diagnosis. Nuzum, in a survey of one thousand operations in known syphilitic patients in the Cook County Hospital, found that ninety-seven useless and unnecessary operations had been performed on eighty-seven patients. Gastric ulcer, gall-bladder disease, appendicitis and salpingitis headed the list (Dean Lewis Surgery). When so many errors are made by competent surgeons in those known to be syphilitics, we can only surmise the mistakes of the less

skillful where syphilis is unknown and probably unsuspected.

On the other hand, the presence of a syphilitic infection is no assurance that the patient may not be suffering from other diseases at the same time. Many a case of known syphilis has suffered from disease of the gall bladder, appendix, salpingitis or other acute surgical diseases, and on account of the known infection operation has been delayed too long.

Secondly, there is an increase of the immediate mortality rate attending surgery. This can only be estimated by the lowered resistance of infected patients, and the less expectancy of life as shown by the life insurance statistics.

Thirdly, syphilis makes for an interference with the healing of wounds in a certain percentage of surgical cases which have been insufficiently treated. To illustrate: A young lady of twenty-five years was operated for the relief of a chronic pelvic inflammatory disease. There was no history of syphilis. There was a history of taking "shots" for anemia. The Wassermann was negative. Following the surgery, there was an uncomplicated recovery until the tenth day. The stitches had been removed and healing had seemed satisfactory when the edges of the incision began to necrose. A thin line of dry gangrene appeared along the edges of the wound. The Wassermann was repeated and found to be positive. Antisyphilitic medication caused prompt healing.

We can see the necessity of requiring a routine Wassermann in all cases admitted to hospitals. The negative history and the routine physical examination are not sufficient assurance that the patient is not infected with syphilis. A disease causing more trouble than any other is worthy of the utmost care in its treatment and cure. While the serologic tests do not always show the presence of existing syphilis, their routine use would do much to eradicate the disease.

Social Phases.—The stigma that attends infection with syphilis is one of the chief reasons for hiding its presence. Few, who find they are infected, are in a position to carry on treatment for a sufficient time to insure even a relative cure without sharing their secret with someone else. If, for no other reason, the expense of the treatment and the necessary precautions that must be taken are sufficient to betray their secret. Rather than divulge their secret, they are tempted to stop treatment when their symptoms are relieved and before a cure could be hoped for.

The injustice of the present system is apparent when we consider the way different crimes against society are punished. The careless individual throws a stone into a crowd and accidentally puts out an eye or scars a face. The offender is fined an amount commensurate with his ability to pay. He may be incarcerated for his act. The same careless individual infects with syphilis. There is no redress, although the patient's entire life may be ruined, as well as that of any offspring.

Possibly a young girl is betrayed and bears a child. The father of the child is held responsible for her condition. He is required to recompense her by marriage and support, or may pay money to support her and her child, as far as he is able.

In the event that he infects her with syphilis, he places a lifelong stigma on her, and yet is not held accountable for his act. The infection not only ruins her life, but also that of any offspring she may have subsequently.

In Conclusion.—Syphilis increases the hazard of operations and jeopardizes the result of surgery. Active syphilis should contraindicate all except emergency operations. The shock of surgery may activate latent syphilis.

A single negative serologic test is no assurance that the patient is free from syphilis. A negative history is of little importance regarding syphilitic infection. Family traditions, social position, religious affiliations, or absence of a history of specific infection cannot be accepted proof of freedom from the infection.

The cure of syphilis is problematical. When the case is seen early and treatment is adequately administered for a year and following, there should be check-up examinations every three months without any treatment. If these tests remain negative for the year, and the spinal fluid Wassermann, cell count, globulin, titrated Wassermann and colloidal are negative, the case may be considered clinically cured. There is no assurance that the cure will be permanent, and Wassermann tests should be taken at intervals for at least ten years. Spinal fluid tests should be repeated on the first untoward symptoms as long as the patient lives.

The prevention and final eradication of syphilis is possible only if the transmittal of syphilis is recognized as a crime and punishable by law.

A negative Wassermann test before marriage, while it is a step in the right direction, is not sufficient to control the disease. Syphilis is spread by many who are not interested in marriage.

Syphilitic infection, even if not transmitted, must be recognized as a misdemeanor and quarantinable unless adequate treatment is being taken. Treatment must be made available to all infected cases.

* * *

II. SYPHILIS IN RELATION TO INDUSTRIAL MEDICINE

HARRY E. ALDERSON, M.D. (490 Post Street, San Francisco).—Industrial dermatoses occur in all trades and occupations, but it is mostly in certain vulnerable individuals that they are seen. Advancing years (past forty), congenitally thin or susceptible skin (allergy), and various underlying constitutional diseases are important factors. Under the last heading, syphilis may be listed as a fairly common cause. Syphilis at all stages not only tends to make the worker less careful, but on account of the tendency that even the latent syphilitic's skin shows to develop syphilomata at the site of traumatism, it often has to be con-

sidered. Also syphilis may at times retard the healing of wounds. So this disease renders its victims poor industrial risks.

Two cases in point were reported by me in 1931.[1]

Case 1.—Mr. C. C. (No. 25948), a Mexican carpenter, thirty-nine years old, presented a typical, non-ulcerating gumma, extending across the left upper orbital margin. There was a similar smaller lesion at the inner end of the right eyebrow, which had been present for several months. The former lesion appeared shortly after the patient was injured in that spot by a piece of lumber on which he was working. An abrasion resulted and it never healed, developing finally into a typical syphiloma. There was no history of syphilis, and the only other evidence found was a strongly positive blood Wassermann. Under neoarsphenamin and bismuth the lesions disappeared.

Case 2.—Mr. P. C. (No. 25190), an Italian laborer, thirty years old, presented a typical, non-ulcerating syphiloma at the right inner canthus. His blood Wassermann was strongly positive. It was impossible to obtain a history or other evidence of syphilis. About two months previously, while cutting wood with a "rip saw" a splinter of wood struck the side of his nose near his eye. The patient pulled out the splinter, and there was some bleeding. The wound never healed, and the syphiloma gradually developed. Under neoarsphenamin and bismuth injections it subsided rapidly.

In each of these two cases responsibility was accepted by the insurance carriers, and the necessary treatment to eradicate the lesions only was authorized.

The following case record, taken from the United States Public Health Reports of 1916, and the quoted court decision, establishes the status of these cases:[2]

A workman was injured by an accident in a sawmill at Traverse City, Michigan. Under the Workmen's Compensation Law, payments were made for a period of nineteen weeks, when the employer refused to make further payments, upon the ground that the employee's continued disability was due to syphilis, which retarded the healing of the wound.

The Michigan Supreme Court, however, decided that payments must be continued. Mr. Justice Person, in the opinion, said: "The consequences of the injury extend through the entire period, and so long as the incapacity of the employee for work results from the injury, it comes within the statute, even when prolonged by preëxisting disease."

Numerous decisions have placed on the insurance carrier the responsibility for medical care of syphilitics who have developed syphilomata as a result of vocational trauma or irritation. (See Klauder[3] and Harry Foerster.[4] Foerster[4] comments as follows:

"Compensation is not dependent on any implied assumption of perfect health, and does not exclude the weak or physically unfortunate, or those with latent and unknown tendencies to disease. The employment of a man is in itself an assumption that he is physically and mentally fit for the work."

Klauder[3] cites numerous examples where traumata of various kinds have determined the appearance of syphilomata at the site of injury. There is to be remembered also the often-quoted example of the occurrence of gummata on the foreheads of Mohammedans, who in their religious ceremonies frequently strike their heads on the marble floor.

With syphilis so prevalent, many of the cases having had inadequate treatment, it is rather discomforting to realize that in positions of responsibility there may exist cases of latent and of neurosyphilis. Stokes[5] reported, in over one thousand cases, eight times as many syphilitics among railroad men as among farmers! His article, which discusses also cerebrospinal complications, is of very great interest. Various other writers have stressed the great prevalence of syphilis among railroad workers, and such workers are frequently exposed to trauma.

Whether or not syphilis is acquired innocently or through carelessness, any occupational dermatoses that may be aggravated by the disease has to be taken care of by the insurance carrier. It would be wise, and perhaps would be the means of lessening disability and saving expense, if every patient with occupational troubles had a Wassermann test done at once.

* * *

III. SYPHILIS IN RELATION TO EYE INJURIES

HANS BARKAN, M.D. (Stanford University Medical School, San Francisco).—It is not an unusual event to find the eye specialist treating an eye inflamed and injured without realizing that the manifestations of the injury may not be due to the direct effects of the trauma alone, but are complicated by the fact that they are partially manifestations of syphilitic processes aroused to activity by the trauma. When one considers the number of dormant syphilitics in the community, one is rather surprised that not more syphilitic post-traumatic manifestations are seen than is the case. To illustrate the point: Only very rarely, if ever, does the eye of a syphilitic, when operated upon for glaucoma or cataract, show any other than a normal course of healing. When, however, the trauma is a blunt one, such as a blow from a piece of wood, or a lead shot striking the cornea, or an eye hit by a piece of swinging rope, just to mention three personal cases, it must be borne in mind that the injury may arouse specific manifestations in an eye so predisposed.

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1 Alderson, Harry E.: Syphilis in Relation to Occupational Injuries, Calif. and West. Med., Vol. 35, No. 6 (Dec.), 1931.

2 United States Public Health Reports, Vol. 31, No. 39 (Sept.), 1916.

3 Klauder, Joseph V.: Syphilis and Trauma, J. A. M. A., 78:1029-1037 (April 8), 1922.

4 Foerster, Harry R.: Industrial Dermatoses, Arch. Dermat. and Syph., 17:585-601 (May), 1928.

5 Stokes, J. H., and Brehmer, H. E.: Syphilis in Railroad Employees," J. Indust. Hyg., 1:419 (Jan.), 1920.

The most frequent of these is interstitial keratitis. Of these, I have seen four cases, published in the *Transactions of the American Ophthalmological Society* in 1926. The patients were all congenital luetics in their thirties and forties, at an age when interstitial keratitis as a congenital manifestation does not occur. In the injured eye in each case there developed, within a week after the injury, a typical keratitis, and in each case the second eye followed after several weeks or months, just as spontaneous cases in children do.

Iritis not infrequently follows a very trivial external injury, and is usually characterized by a severity out of all proportion to the external blow on the lids or eyeball. In one case I saw it develop as a typical iritis papulosa.

Blows of minor severity on or about the eye can be followed by periostitis of the supra and intraorbital margins as luetic manifestations. I have seen only one instance of this. Igersheimer, in *Syphilis und Auge,* states that luetic retinitis, choroiditis, and neuritis may follow blunt trauma in the luetic, but it seems to me that these sequelae, while they may occur, must be very rare and isolated cases.

The main interest, for practical purposes in the coincidence of trauma and syphilis in the eye, consists in the fact that a number of patients claim compensation disability, and we are occasionally asked to act as referee in such cases. The position I took in regard to this in several instances is as follows: First, the case must be seen on the day or not later than two or three days after the injury, so that the primary effect of the injury is still evident, and examination of the cornea and iris discloses that the process is not one distinctly antedating the injury. Second, the injury must be sufficient, and we must take our stand firmly against such injuries claimed as dust in the eye, exposure to wind or draft, cocain or atropin in the eye, conjunctivitis, etc. In review of the case which must be accepted, the trauma has always been a forcible striking of the corneal tissue, even though by a small object involving the breaking of the continuity of the tissue, or a blow of sufficient severity to cause deep hyperemia and disturbance of the lymphatic circulation of the eye. Third, the luetic effects must appear in a week or two after the injury, and fourth, the process must be typical, so that no doubt of the diagnosis can arise.

If we assume that the relationship of trauma to interstitial keratitis is only accidental in time, there is no such problem to be considered. We simply deny that interstitial keratitis is the result of any claimed trauma. If we believe that there are enough authentic cases, ruling out all cases of trifling injuries, conjunctival inflammations, nonirritating chemical or gaseous contact with the cornea, such as soap, atropin, etc.; and ruling out, also, many reported cases which were probably not interstitial keratitis at all—if, doing all this, we are still convinced that there are enough legitimate cases to establish beyond question the fact that trauma is of etiologic moment, we must maintain in such a case that the particular trauma can cause the luetic eye manifestation, and that, consequently, all the time of the disease is compensable, and the permanent loss of vision, to be estimated one year after the last inflammatory symptoms have disappeared, to be compensated.

Coutard's Method of Treatment of Cancer.—Since the results of Coutard therapy in the treatment of cancer of the larynx, pharynx, and hypopharynx have been so far superior to any present or previous method, Chamberlain and Young believe that no other procedure should be considered when roentgen treatment for the disease at these sites is indicated. The same statement holds for cancer in certain other organs, for example, the cervix, breast, bladder, esophagus, bronchus, and rectum, although it is often necessary to modify the dosage, depending on the size and location of the tumor and the condition of the patient. In those lesions which respond to Coutard therapy better than to "massive doses," the advantage of the protracted fractional dose method must rest on the existence of a more rapid "recovery rate" in the skin than in the tumor. There are tumors requiring massive doses just as surely as there are tumors that require the method of Coutard. Certain small superficial growths are completely destroyed by a single large dose of from 3,000 to 5,000 roentgens with complete assurance that the resultant ulcer, of small size, will heal completely; for example, a small or moderate-sized, isolated nodule of recurrent mammary cancer in an accessible or superficial location. A plan of monthly doses of from 300 to 800 roentgens (usually in a three- or four-day series) is considered by the authors whenever they are faced with (1) a highly roentgen resistant tumor and a microscopic structure that indicates a high degree of tissue differentiation (fibrosarcoma, neurofibroma, metastasizing thyroid adenoma) or (2) when the element of vascularity is an important factor (hemangioma, certain telangiectatic tumors of the spinal canal, some highly vascular but relatively radiation-resistant sarcomas of the bone). While the literature appears not to contain any analytic references to this type of technique, it is obvious that Newcomet, Ewing, Ginsburg, and others, have consciously or subconsciously adopted some such method.—*Radiology.*

The Art of Thinking.—Whoever lacks a ruling interest will fail to make the most of his mind; for without such training and experience as the long-continued pursuit of a subject gives, the intellect does not develop its power. Nor will the man of too many interests grow to his full mental stature. Mental growth in mature life, as shown by Spinoza and other examples, is fostered by nothing so much as an absorbing aim.

He who has a liking for a science or an art, for a branch of literature or period of philosophy, for the life of a great man, the history of a people, or other line of inquiry, is already on vantage ground. He is in a position to gain both insight and outlook. A point here and a point there will be located by the aid of which he may not only survey his own field, but also orient himself in wider provinces of knowledge. Thus he may hope to find some of the fundamentals of truth and life.

Through coping with problems, through investigation, reflection, and discussion, he will learn how to think. Meanwhile he will have a joy in books unknown to the haphazard reader; he will see more in life and the world than meets the casual eye. His days will be remote from the tragic need of killing time, for his leisure will be full of contentment, often of happiness and zeal.—Leon J. Richardson.

Adult education is in one sense a youth movement. Consider the countries involved. They are mainly the ones where English, the Scandinavian languages, German, and French are spoken. This fact is significant. In science, literature, and other fields of sound thinking, the peoples using these languages take high rank. They are progressive, giving much attention to the problems involved in bettering human life.

CALIFORNIA MEDICAL ASSOCIATION

This department contains official notices, reports of county society proceedings and other information having to do with the State Association and its component county societies. The copy for the department is submitted by the State Association Secretary, to whom communications for this department should be sent. Rosters of State Association officers and committees and of component county societies and affiliated organizations, are printed in the front advertising section on pages 2, 4 and 6.

CALIFORNIA MEDICAL ASSOCIATION

THIS MONTH'S TOPICS*

ASSOCIATION ACTIVITIES

1. *Council Meeting.*
2. *Annual Dues.*
3. *American Medical Association Secretaries and Editors' Annual Conference.*
4. *Panel Jobs and Cut-Rate Fees.*
5. *Read Your Liability Policies.*
6. *Postgraduate Conferences.*
7. *Council on Industrial Medicine and Surgery.*
8. *Permanent Endowment Fund.*
9. *Membership.*
10. *Executive Committee Minutes: Digest.*
11. *Passing Comment.*
12. *Drug-Sample Rackets.*

DEPARTMENT OF PUBLIC RELATIONS

1. *Cut-Rate Fees.*

ASSOCIATION ACTIVITIES

COUNCIL MEETING

The Council of the California Medical Association will convene in regular session in Los Angeles on Saturday, January 15, 1938, at 9:30 a. m. The meeting will be held in the Lounge of the Los Angeles County Medical Association headquarters building.

Any county society, committee, or member having any proper matter requiring consideration by the Council is requested to transmit their question to the State Secretary.

ANNUAL DUES

January, marking the beginning of a new year, is the month during which members should pay their annual county and state dues for the current year.

The State Association dues for 1938 were reduced from $15 to $10 by the House of Delegates at the Del Monte annual session, and are payable this month to your county secretary, who will remit to the State Association offices. In due course you will receive your state membership certificate.

It is suggested that you remit your county and state dues to your county secretary today. Relieve him of the extra labor of having to assume the rôle of collector. *Send him your check today.*

AMERICAN MEDICAL ASSOCIATION SECRETARIES AND EDITORS' ANNUAL CONFERENCE

The Association's editor and secretary attended this conference at the American Medical Association headquarters in Chicago on November 19 and 20. The following constituted the formal program, and was productive in transmitting much helpful information as to activities of state organizations.

ANNUAL CONFERENCE OF SECRETARIES OF CONSTITUENT STATE MEDICAL ASSOCIATIONS, 1937

American Medical Association Building
535 North Dearborn Street, Chicago

PROGRAM

Friday, November 19, 10 a. m.

Call to Order. Arthur W. Booth, Chairman, Board of Trustees of American Medical Association.

Address. J. H. J. Upham, President, American Medical Association.

Student Health Services: A Challenge to Medical Societies. J. D. Laux, Bureau of Medical Economics of American Medical Association.

Extension (Postgraduate) Courses of State Medical Associations. Walter F. Donaldson, Pittsburgh; Creighton Barker, New Haven, Connecticut; T. W. M. Long, Roanoke Rapids, North Carolina; Holman Taylor, Fort Worth, Texas.

The Uses and Benefits of Exhibits Under Auspices of State Medical Associations. Eben J. Carey, Milwaukee.

12:30 p. m. Luncheon.

Friday, November 19, 2 p. m.

Address. Irvin Abell, President-Elect, American Medical Association.

The State Association and the Social Security Act:
- New Jersey's Coöperative Program for Maternal and Child Health. LeRoy A. Wilkes, Trenton, New Jersey.
- Coöperative Program of the Illinois State Medical Society. Harold M. Camp, Monmouth, Illinois.

The State Association's Part in a Pneumonia Control Program. Peter Irving, New York.

Friday, November 19, 6:30 p. m.

Palmer House

Dinner Meeting of Editors of State Medical Journals. E. M. Shanklin, Hammond, Indiana, Presiding.

Better Papers for State Medical Journals. J. H. Dempster, Detroit.

Round-Table Discussion:
- Publication Costs.
- Typographical Arrangement.
- Cross References.

Saturday, November 20, 9:30 a. m.

Two Important Legal Problems: Malpractice Claims; Taxation Under Federal Revenue Acts and Social Security Act. W. C. Woodward, Director, Bureau of Legal Medicine and Legislation of American Medical Association.

Topics for General Discussion:
- Secretary's Bulletins for Officers or Members.
- By-Laws Pertaining to Membership and Disciplinary Measures.
- Rural Rehabilitation Plans of Federal Government.
- Independent Societies.
- Automobile Accidents.

Editorial comment and letters published in the December issue transmit to each reader the serious question that concerned the conference. Every member should carefully read the editorial and the communications and devote time in consideration of their portent.

Under the democratic plan of our medical organization, channels and methods have been created for the presentation and consideration of any principles, policies or plans that any member, individual or groups of members or individuals may feel should receive attention and action.

That which organized medicine has accomplished has been attained through these channels by constituted representatives. The channel is an open one, and is continuously operative.

Independent or coterie action is disorganized action and as such is unwise, and deserves no support.

Need more be said than to remind all members that our organizational strength and unity is the more potent force in conserving our individual and collective future. Let that thought remain uppermost when independent proposals are presented to medical men.

*All articles listed under the caption, "This Month's Topics," have been written and sent to the Editor by the Association Secretary, Dr. Frederick C. Warnshuis.

PANEL JOBS AND CUT-RATE FEES

Members are approached from time to time by representatives of corporations, insurance companies, lay groups and organizations seeking to secure medical services at bargain rates, greatly reduced from the prevailing schedule.

Within the past month county societies and individual doctors have been approached by an Automobile Insurance Company representative seeking to secure medical services, when needed, for its policyholders. The representation is made that if the doctor will render medical and surgical care to these policyholders for fees 25 per cent below the present compensation fee schedule, his name will be placed on the panel of the insurance company doctors and this business will be sent to him.

The old bait! One for which the unthinking doctor will fall, and be the sucker while the company pockets increased profits at the doctor's expense.

Compensation fee schedules are now below the regular fee schedules. Why should you accept a still further reduction under the sales urge of the company that paints pictures of increased volume of practice and income? Why should a company seek reduced fees, prey upon the doctor, lower his just income and seek these exceptions and favors? Simply to lower their liability expenses, lessen their costs and increase company earnings and dividends at the expense of the doctor.

In all such quests and approaches the member should refer the entire matter to the officers of his county medical society and abide by the policy of his society. There must be no cut-rate fees. Do not fall for the gush of these representatives who hold out the bait of increased volume of exclusive business, special qualifications, etc.

Before signing up, consult your county secretary. Do not undercut your fellow practitioners.

READ YOUR LIABILITY POLICIES

Again we have seen this month three policies issued to members and which these members thought gave them adequate insurance protection. They did not! Exceptions and noncoverage were for *"nonemergency* operations," protection defense only for suits arising *"within* the year the policy was in force" and not for suits brought from one to two years later or in the instance of minors who can start a suit within two years after they attain their majority. A hidden clause wherein the company can settle without consulting the holder of the policy.

Hence the warning is issued anew! Read your policy and learn if you have adequate protection.

POSTGRADUATE CONFERENCES

On December 2, the first postgraduate conference under the new five-year program of the Association was held in Eureka. Thirty of the thirty-four members of the Humboldt County Medical Society attended. Three of the members drove 176 miles to participate in this conference.

Dr. Stacey Mettier of the medical department of the University of California presented the subject of arthritis. Dr. H. Glenn Bell of the same school covered the subject of acute involvement of the gall-bladder.

Councilor Henry Rogers and the State Secretary presented the outline of State Association policies and activities.

* * *

On December 9, President Morrow, Councilor Rogers, and the State Secretary were speakers at a well-attended meeting of the Marin County Society. Doctor Morrow presented a lantern-slide clinic on syphilis and discussed State activities in venereal disease control and treatment. Councilor Rogers and the Secretary discussed Association activities.

It was an excellent meeting, but in an unusual heavy rainstorm the President and the Secretary made a wrong turn and got off the road and became mired in a ditch and almost two-mile walk in a drenching rain to a telephone brought the County Secretary with a chain. However, power was lacking to pull the car back on the road, so it was abandoned temporarily and journey resumed in the County Secretary's car, and here another but—he, too, got lost in the hills in his own bailiwick. Aimless driving eventually landed us in his own city where, oriented anew, he delivered us at the meeting place some two hours late and two state officers thoroughly soaked—with water from shoulders to feet, but even this did not dampen a very interesting and worth while evening meeting of the Marin County Medical Society.

COUNCIL ON INDUSTRIAL MEDICINE AND SURGERY

A resolution passed by the American Medical Association House of Delegates last June directed the Board of Trustees to appoint a Council on Industrial Medicine and Surgery. The following appointments have just been announced: Stanley J. Seeger, Milwaukee, Chairman, Harvey Bartle, Philadelphia; Warren F. Draper, Washington, D. C.; Leroy U. Gardner, Saranac Lake, New York; Morton R. Gibbons, San Francisco; Henry H. Kessler, Newark, New Jersey; A. D. Lazenby, Baltimore; Earl D. Osborne, Buffalo; and C. W. Roberts, Atlanta, Georgia. The Council held its first organizational meeting in Chicago on December 10.

Our congratulations are extended to Dr. Morton R. Gibbons, Sr., on his appointment as a member of this Council. Doctor Gibbons' ability and long years of experience will make him a most valuable member and give assurance that this newly created Council will accomplish needed regulations, policies, and results. California's profession is gratified by Doctor Gibbons' appointment because it is felt that these peculiar problems in California will receive careful consideration.

PERMANENT ENDOWMENT FUND

Contributions to date—$200 from two members! A rather disheartening response to the several editorials and items in previous issues. Surely, there are 998 members who can subscribe $100 or more to establish this permanent endowment fund, whose principal will remain intact in perpetuity. Will *you* be one of them?

The income earnings of this fund will be appropriated to defray the expanding activities of this Association, particularly our five-year postgraduate program opportunities and the program of public education.

Please pause and consider what amount you can subscribe to this fund and remit it today. One hundred dollars—or one thousand, and maybe more. The Council urges that you aid in establishing this fund.

MEMBERSHIP

Because occasionally misunderstanding and confusion arises regarding the status of members in their county and state medical organizations, the Constitution and By-Laws governing membership are reprinted:

Article IV.—Membership. (a) Active Members. Qualifications.—Active members shall comprise all active members of all the component county societies. No person shall be eligible for election to active membership in a component county society unless he shall hold the degree of doctor of medicine issued to him by an institution of learning accredited at the time of conferring such degree by the American Medical Association or the Association of American Medical Colleges. He must also hold an unrevoked license to practice medicine and surgery in the State of California; provided, however, that, subject to the minimum qualifications prescribed by this Constitution and the By-Laws, each component county society shall be the exclusive judge of the qualifications of the members thereof.

Membership in the American Medical Association does not, *ipso facto,* mean that one is a Fellow of the American Medical Association. To be a Fellow of the American Medical Association, one must make special application and pay an additional $7 to the American Medical Association for fellowship annual dues. The perquisites of fellowship are: (1) Receiving the *Journal of the American Medical Association.* (2) Admission to all the exhibits, general and section sessions of the annual meeting. (3) Right to participate in the scientific meeting programs. (4) Eligibility to appointment or election to offices, councils, committees and bureaus, and membership in the House of Delegates.

Many members are under the impression that they are Fellows because they subscribe to the *Journal of the American Medical Association* and remit $7 annually. It is imperative that you apply for fellowship. If you are a

Fellow you will receive a Fellow's pocket card, necessary to register at an annual session and gain admission to *all* annual functions.

Search your wallet or files and ascertain if you have a fellowship card. If not in your possession, then it is recommended that you file the proper application—obtainable from your county secretary or your state secretary.

EXECUTIVE COMMITTEE MINUTES: DIGEST

The Executive Committee of the Council met in San Francisco on December 11.

1. Malpractice liability insurance questions were referred to the Committee on Malpractice, to report on January 15, 1938.

2. Secretary authorized to reissue charters to county societies whose original charters were lost.

3. A Mexican vacation tour was sponsored.

4. Membership Roster of 1937 was ordered published as a supplement to the February journal.

5. Hospitalization plans of Southern California Associated Hospitals was referred to Committee on Public Relations for report on January 15, 1938.

6. Qualifying Certificate Committee requested to submit detailed report on January 15, 1938.

7. Routine matters discussed and acted upon.

8. January 15, 1938, was fixed as date for the next regular Council meeting in Los Angeles.

F. C. WARNSHUIS, *Secretary.*

PASSING COMMENT

It costs the government $900,000 per year for treatment of men in the ranks of the CCC for venereal infections.

* * *

The "Elixir Sulfanilamide Tragedy" has caused some stir in congressional circles. It is hoped that this tragedy and loss of seventy-three lives will induce Congress to enact needed legislation to control the manufacture and sale of potent drugs and remedies. Write to your United States senators and congressmen urging their support of this needed legislation.

Drug manufacturers are applying to the Council on Pharmacy and Chemistry for approval of their preparations.

Do not use, administer or prescribe nonapproved drugs or compounds. Rely upon this safeguard for your patient and yourself.

* * *

You will please your county secretary if you will send your check today for your 1938 county and state dues. Relieve him of the rôle of a dunning collector—he will have more time to devote to other official duties.

* * *

May 9 to 12 is the date, Hotel Huntington in Pasadena is the place for our 1938 annual session. Write today to the manager of the Hotel Huntington for your room reservations. A truly worth while program is about completed. Four very noted guest speakers have accepted invitations to address that session. Commence now to plan to attend.

* * *

Certificates of membership are standard in size. Purchase a frame and display your certificate in your reception or consultation room. Your patients want to know if you are a member of a county society.

* * *

Refer to the front advertising section of each issue for list of state officers, committees, county societies and their presidents, secretaries, and time of meeting each month. While doing so don't fail to read the advertisements and patronize these patrons of your official journal.

* * *

If in doubt as to the coverage contained in your liability insurance policy, the central headquarters office will be glad to review it for you. Your inquiries are welcome. Be sure to read your policy and ascertain if you are adequately protected. Some policies contain many exceptions.

You throw away money if you pay for the listing of your name in any of the so-called special directories. No business will accrue to you from such listing. It is a sales racket for the sole profit of the publisher.

* * *

Read and know—before signing any document or statement.

* * *

One wastes time perusing the items in publications that are sent to you free. They have been well designated as "Throw Away Publications." You do well to throw them away unread and to devote your time reading recognized journals. Most of these free publication articles are calculated to lead you to prescribe nostrums and unapproved remedies that are of little value. Cease being a "capper" for these drug manufacturers. Read and patronize the advertisers of official medical journals. Be wise.

* * *

We are off to a big year—a fine annual session in Pasadena in May, a definite program of postgraduate instruction for each councilor district, a similar program of lay public health education meetings, the annual session of the American Medical Association in San Francisco, and a general election in November with several vital initiatives on the ballot. Of equal importance are the county society regular meeting programs. Medical history will be made in California in 1938.

* * *

In the event of patients complaining of pain in their lower extremities, it is extremely important that your examination eliminate the diagnosis of thromboangiitis obliterans. This point in diagnosis is particularly important before administering electrotherapy treatments or performing any surgical operation on the toes or feet. Failure to observe this precaution may cause you to undergo some untoward experiences.

* * *

"Do you have any doctors around here?" asked a traveler in a remote wilderness region of the Ozarks.

"Hell, no, we don't want no doctors," replied the bewhiskered native, shifting his tobacco from one corner of his mouth to the other.

"What do you do when somebody is sick?" said the traveler.

"We give him a good drink of whisky."

"Suppose that doesn't do him any good; what then?"

"Then we give him another drink."

"And what if that doesn't help him?"

"We naturally give him another."

"And if that doesn't make him better?"

"Stranger, if a man is so sick that three drinks of whisky don't do him no good, then nobody can't do nothing for him."

The above was lifted from the *New York State Journal of Medicine*. Such individuals compose the group, cited by propagandists and economists, that are without medical care. They are not all confined to the Ozarks.

* * *

The Westchester County *Bulletin* states that "doctors spend an average of $820 per year from their income for insurance protection for life, accident, health, malpractice, automobile, public liability, and compensation." This is deemed to be necessary for their financial and business protection.

Yet, when it comes to county medical society membership and the annual dues, the question is raised as to the value and benefits of membership. Your county medical and state medical associations insure and safeguard your practice and professional interests. Insurance of this nature is not purchasable anywhere other than from your county society. Remember this when paying your annual dues.

DRUG-SAMPLE RACKETS

Is your office attendant, secretary, or nurse abetting this racket? Drug manufacturers advertise in good faith their willingness to send you generous samples of their products and leading preparations.

Thousands of dollars of such samples of standard and approved preparations and drugs are sent monthly to physicians answering these advertisements.

Now steps in the racketeer. He calls at your office, usually outside of your office hours and represents to your office attendant that he is a detail agent. He induces your employee to drop a card or coupon to the manufacturers

requesting samples in your name and instructs her to keep them until he returns in ten days or two weeks. In due time he calls, collects the samples and gives to your employee a dollar, a pair of stockings or a box of candy, and departs with the samples.

By such means the racketeer is able to collect unbelievable quantities of expensive drugs and preparations which are, in turn, sold to certain drug stores at greatly reduced prices, yet at a price that yields him handsome financial returns.

Recently a large manufacturer, upon receipt of an unusually large number of requests for samples from a certain locality, sent the samples to its local detail representative, with instructions to deliver in person to the physicians whose purported request had been received. In over 80 per cent of requests, the doctor admitted that he had not sent in for the samples, but recognized the writing of his employee. These employees admitted that they had been induced to send in the request for samples by a person who alleged he was the manufacturer's representative. In another check-up, a different manufacturer uncovered similar methods of the racketeer.

Physicians can and should put an end to this racket and assist in freeing well-intentioned manufacturers from this imposition. This does not mean that you should cease responding to advertisements, because manufacturers are desirous of meeting your requests for samples. It does mean that you instruct your employees to not give away the samples you receive.

C. M. A. DEPARTMENT OF PUBLIC RELATIONS†

Cut-Rate Fees

A certain automobile insurance company has been, and probably still is, endeavoring to secure the services of one or more physicians in different centers to provide medical care for cases in which it is liable. The bait of "sending all cases to one doctor," "exclusive doctor," volume of business is cast to induce the doctor to sign a contract to render these services for fees scheduled at 25 per cent below the present compensation fee schedule. Just why this company should believe it is entitled to cut-rate fees is not evident. Just why a doctor should cut fees is unexplainable as no justification for doing so exists.

We commend and urge each county society to adopt the following resolution of the San Joaquin County Medical Society:

SAN JOAQUIN COUNTY MEDICAL SOCIETY

December 4, 1937.

"That the Board of Directors of the San Joaquin County Medical Society go on record against accepting any cutting of fees or rebating of the same from the existing Industrial Fee Schedule to any Industrial Accident Insurance Company." This action was further amplified at a meeting of the San Joaquin County Medical Society held December 2, 1937, when the following motion was passed. "That the San Joaquin County Medical Society be placed on record as unalterably opposed to fee splitting or reduction of fees or rebating of fees to the Industrial Accident Insurance Company, that a copy of this resolution be mailed to all members of the San Joaquin County Medical Society and the National Automobile Insurance Company, and that any member accepting work from any insurance company entailing reductions of fees, splitting of fees or rebating of fees be referred to the Committee on Ethics and Professional Conduct for such disciplinary action as the committee sees fit."

This action of the Board of Directors of the San Joaquin County Medical Society and of the San Joaquin County Medical Society is called to your attention so that you might govern yourself accordingly.

Yours sincerely,

G. H. ROHRBACHER, M.D.,
Secretary.

† The complete roster of the Committee on Public Relations is printed on page 2 of the front advertising section of each issue. Dr. Charles A. Dukes of Oakland is the chairman, and Dr. F. C. Warnshuis is the secretary. Component county societies and California Medical Association members are invited to present their problems to the committee. All communications should be sent to the director of the department, Dr. F. C. Warnshuis, Room 2004, Four Fifty Sutter Street, San Francisco.

COMPONENT COUNTY MEDICAL SOCIETIES

ALAMEDA COUNTY

The annual meeting of the Alameda County Medical Association was held at Hunter Hall on Monday, November 15, 1937, at 8:15 p. m., President MacLean presiding.

The following program was presented:

1. *Reports on Legislative Matters* by Ben Read. Mr. Read reviewed the proceedings of the last State Legislature.

2. *Progress Notes on Insurance Association of Approved Hospitals* by Dr. Daniel Crosby. Doctor Crosby reminded the Association that our insurance project is just one year old, the charter having been received on November 16, 1936. He outlined progress, quoted statistical data and discussed the problems which are still ahead.

3. *Tuberculin Test in Connection with Part-Pay Patients* by Doctor Bush. The tuberculin tests should be considered important clinical procedure. He pointed out that the Anti-Tuberculosis Association was making every effort to aid the doctors.

4. *Reports of Committees* as follows:

A. *Report of the Publicity Committee:*

A year ago the appointment of the chairman of the Publicity Committee for the Medical Association was made. The president acted wisely in appointing one member of the Association for each of the standardized hospitals in the county. The program which has been adopted and followed throughout the year has taken into consideration two general principles. First, that the publicity appearing in the various newspapers shall be ethical in character and reflect credit and not reflect discredit upon members of the profession or upon the hospital and secondly, to create a cordial relationship between the various newspapers, the hospitals, the physicians in practice and the profession as a whole. This second proposal has been of great importance and opens a wide field that deserves more cultivation.

The Alameda County Medical Association, a number of years ago, discontinued any connection with any publicity bureau or paid publicity man. While this seemed wise at the time, it does seem to me now that if possible some arrangement should be made so that a definite publicity program could be positively carried out in a fashion that would again have for its purpose the publicizing of appropriate cases, matters of interest happening in the professional world, and particularly some attention given to trends in medical practice.

At no time has the public indicated a greater desire than now to learn of medicine and its problems as well as trends looking toward practice and changes in methods of practice.

Not nearly enough has been accomplished during the past year, but at the same time no particular damage has been done. Under an aggressive program of publicity it is believed that much might be accomplished in years to come, should the Association undertake such a program.

Respectfully submitted,

Signed: B. W. BLACK, M. D.,
Chairman, Publicity Committee.

B. *Report of the Library Committee:*

	1936	*1937*
Attendance	1311	1318
Circulation:		
Books	690	814
Periodicals	2171	2203
Total	2861	3017
Reference questions		1119

Attendance and circulation show another slight increase over the previous year. The number of books added from the fund allowed by the Medical Association was forty-two; gifts, five; one subscription was added to the journals, making a total of eighty-three. A contribution of duplicate numbers of journals was made to the Medical Library Exchange, and several journals needed to complete files were received from the Exchange.

Shelf space was becoming crowded and an additional double-faced stack was installed which will take care of the increase for three or four years.

It was decided by the Library Committee to start a collection of reprints of publications of members of the Association, starting with 1930, and a notice was put in the *Bulletin*. Many contributions to the collection have been made, but it is not yet complete. Any members having reprints of which the library does not have a copy, please let us have one.

The librarian attended the annual convention of the State Library Association at Yosemite in May.

The Library Committee again wants to express its appreciation of the careful conscientious work of our Librarian, Miss Kennedy. After all, a working library is not merely a collection of books and journals, but is largely built around the intelligent service of a skilled librarian.

We also want to thank and to commend the many members of the Medical Association, who both personally and by letter, have given to the Library Committee helpful suggestions and constructive criticism.

H. G. TRIMBLE, *Chairman,*
WALLACE T. PARTCH,
HAROLD MALONEY.

C. *Report of the Committee on Public Health:*

The Committee on Public Health has coöperated with the Chamber of Commerce throughout the past year. No items of unusual interest have been encountered.

F. S. BAXTER, *Chairman.*

D. *Report of the Milk Commission:*

Personnel:

The Commission continues to operate under the same personnel as last year, namely, Dr. T. C. McCleave, President; Dr. Edith M. Myers, Secretary; Dr. A. Laurence Gleason, Dr. Rexford Hoobler, and Dr. Ira O. Church.

Dr. Charles J. Parshall of the staff of the Department of Animal Husbandry, of the University of California, is the veterinarian in charge of dairy inspection and laboratory examination. Dr. H. H. Darling of the San Francisco Commission continues to be the examining physician of employees of the dairies for both the San Francisco and Alameda County Commission.

Miss Ruth Manning continues in her rôle of secretary to the Commission maintaining the Commission's headquarters in the Ethel Moore Memorial Building, 121 East Eleventh Street, Oakland.

Meetings and Inspection Trips:

Eight meetings have been held during the year. Two additional meetings have been held jointly with the San Francisco Commission. Five inspection trips were made to the dairies by the members of the Commission.

Dr. Edith Meyers was the Commission's representative to the Atlantic City meeting of the American Association of Medical Milk Commissions in June this year.

Dr. Karl Meyer represented both the San Francisco and Alameda County Commissions at a meeting of the California Association of Medical Milk Commissions held in Los Angeles on April 16 of this year, and at a conference of the Committee on Methods and Standards of the National Association of Medical Milk Commissions held in New Orleans.

Dairies:

Two dairies, Meadowlark Dairy at Pleasanton and Burrough Brothers Dairy at Knightsen were certified by the Commission for the first three months of the present year. On April 1, 1937, Burroughs Brothers Dairy withdrew from such certification on account of other more absorbing interests in the milk industry.

Finance:

Collections and disbursements have been handled by the secretary of the Alameda County Medical Association this year, as in the past year. The amount of funds on hand at the present time is $335.11. All bills are paid and all collections are up to date.

Methods and Standards:

Considerable difficulty has been experienced this past year in keeping within the law in the matter of Methods and Standards, as certain revisions made a year ago by a committee made up of eastern representatives could not be applied to our western dairying conditions. This was corrected, however, at the National meeting in Atlantic City.

Dairy Improvements:

Meadowlark Dairy is, at this time, completing a six months' program of rebuilding. In accordance with modern dairy planning, a large new building of reinforced concrete has been constructed. It will house in its various units, a feeding and washing barn, a holding pen and a milking barn; a bottle washing room and bottle storage room, a very large refrigerating room and a bottle filling room. New and modern equipment is being purchased and installed throughout. The plant is a model of a small dairy and to accommodate the many visitors who are drawn by its wide reputation, large plateglass outside windows have been installed in the rooms—all of which are on a level with the ground.

EDITH M. MEYERS,
Secretary, Milk Commission.

5. *Reports of the Officers:*

A. *Report of the Secretary:*

During the year 1937, twelve regular and one special council meetings have been held. There have been ten regular monthly meetings at which scientific programs were presented. Thirty-five of our own members and one invited guest, Dr. Dudley Smith, furnished the programs.

Twenty-seven applicants were elected to regular membership and two members were received on transfer from component county societies. Thirteen junior associate members were elected to regular membership and one junior associate member was denied regular membership. Thirteen applicants were elected to junior associate membership. Eight regular members and one junior associate member resigned, six were elected to retired membership. Four regular members died, five transferred to component county societies, six were dropped for nonpayment of dues.

Active members, 501. Junior Associate members, twenty-six. Associate members, two. Retired members, twenty-four. Total, 553.

Submitted at the annual meeting, November 15, 1937.

GERTRUDE MOORE, *Secretary.*

B. *The Treasurer* submitted the report of the auditors.

C. *Report of the President:*

Members of the Alameda County Medical Association:

During the year ten regular monthly meetings were held, at which time an attempt was made to present well-balanced programs on common subjects of interest to all but especially to those practicing general medicine. These meetings have been very well attended. There were no special scientific meetings. The suggestion is made that the giving of a prize to the doctor presenting the best clinical paper during the year be considered. Everyone likes to be rewarded for an effort of distinction.

The Council entertained the Secretary of the American Medical Association, Dr. Olin West, at which time a discussion took place concerning the part Oakland will play during the convention of the American Medical Association in 1938. Also, the secretary of the Bureau of Economics of the American Medical Association lunched with members of the Council, at which time various economic problems were discussed.

The first annual "Hobby Show" took place, and it was surprising to see what beautiful work of various sorts was presented by our members. The show was enjoyed by all who saw it. It is hoped that it will be continued at varying intervals in the future.

The annual banquet was well attended and, for the first time in many years, the doctors entertained their ladies. Judging from the spirit of good fellowship and the amount of jollity which was evident, the object of the banquet, which was to promote friendship among members of the profession, was attained.

Throughout the year, the Council has been endeavoring to get the Approved Hospitals of the Eastbay to make it a ruling that no one be allowed to practice medicine within their walls who is not a member of his County Medical Association. If this were done, unethical physicians, and especially those who verge on quackery, would be forced to go to hospitals where their type of medicine would be, undoubtedly, highly appreciated. It is hoped this effort will continue.

Efforts have also been made to develop a Publicity Bureau through which all medical publicity would pass. The newspapers are agreeable to this and have stated that they will not publish anything except criminal publicity con-

cerning doctors if this plan is carried out. A publicity bureau of this type would do the doctor a great deal of good in printing only accurate information concerning medicine and keeping out misinformation and also publicity which smacks of advertising. It is the plan of Council to finish this piece of work.

Inasmuch as this year was one in which legislators met in Sacramento, much time was devoted to the obtaining of proper legislation and to keeping out improper, destructive legislation. A great deal of this work is done through the California State Medical Association but that Association is greatly aided by the Public Health League, in the membership of which Alameda County boasts only about 175. It is surprising the amount of good work the League has been able to do with the small amount of money it has to work with. It is urged that all members of our Association who can, join the Public Health League. It costs $5 per year and is an excellent form of insurance.

Undoubtedly, during the coming year, some various forms of socialized medicine will be pressed for by governmental agencies. In our own county, the Insurance Association of Approved Hospitals has gone steadily forward and has expanded to surrounding counties. This is undoubtedly a step in the right direction, as it still leaves the proper doctor-patient relationship. Aside from this, we all know there is a large group of individuals that do not get adequate care and this is largely a "white-collared" group of people. As time goes along, some scheme may be worked out which will help care adequately for this deserving group of hard working individuals. So far, the various plans of State medicine which have been presented would, without doubt, degenerate into another form of political bureaucracy.

I wish to thank all the members of the Medical Association for the fine coöperation they have given during the past year. H. GORDON MACLEAN, *President.*

D. *Report of the Board of Tellers:*

Number of ballots cast, 277; number of ballots discarded because of improperly signed envelopes, five; number of ballots discarded because improperly marked, four.

Officers elected:

President, Dr. Clarence DePuy; Vice-President, Dr. Frank Bowles; and Secretary-Treasurer, Dr. Gertrude Moore.

Council:

Rural: Dr. Clifford W. Mack. Oakland: Dr. H. G. MacLean, Dr. Frank Makinson.

Delegates:

Dr. Leonard Barnard, Dr. John Dougherty, Dr. Sumner Everingham, and Dr. H. J. Templeton.

Alternates:

Dr. T. F. Bell, Dr. W. G. Donald, Dr. Fred Ewing, Dr. Lloyd Kindall, Dr. George Nesche, Dr. Robert Peers, Dr. T. Eric Reynolds, Dr. A. C. Siefert, Dr. D. D. Toffelmeir, and Dr. H. G. Trimble. D. M. ALLEN,
Chairman of Board of Tellers.

Doctor MacLean then presented Dr. Clarence DePuy, newly elected president. Doctor DePuy spoke briefly of his plans for the coming year. The members were reminded of the meeting to be held in San Francisco to hear Dr. Morris Fishbein.

There being no further business, the meeting adjourned.
GERTRUDE MOORE, *Secretary.*

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FRESNO COUNTY

The annual meeting of the Society was held on December 7, 1937, at the University Sequoia Club.

The proposition for membership of Dr. H. W. Pasley was announced.

The following were elected members of the Society: Ernst Aronstein, J. F. Bolkovatz, A. C. Pattison, E. R. Schottstaedt, J. A. Thorman, and J. E. Young.

The annual reports of committees were read.

It was moved by Doctor Pettis, seconded by Dr. J. R. Walker, that the Society endorse the antivenereal disease advertising campaign of the Fresno *Bee*. The advertisements are subject to censorship by the Publications Committee, and without financial obligation to members of the Society. The motion was carried.

The following officers for 1938 were elected: Henry Randel, president; Otto Diederich, first vice-president; R. W. Dahlgren, second vice-president; L. R. Nielson, secretary-treasurer; J. M. Frawley, librarian.

Delegates—G. W. Walker, E. J. Schmidt, and R. S. Scott.

Alternates—C. I. Pendergrass, S. A. Quinby, and B. Sorauf.

Board of Directors—J. M. Frawley.

Doctor Anderson spoke on the danger of buying the wrong kind of Lloyds malpractice insurance, of which there are some thirty different kinds. He advised members to consult Hartley Peart, General Counsel of the California Medical Association, before buying.

The scientific program consisted of talks on *Purpura Hemorrhagica* by Dr. Stacy Mettier of San Francisco, and *Acute Gall-Bladder* by Dr. Glenn Bell of San Francisco.
O. B. DOYLE, *Secretary.*

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HUMBOLDT COUNTY

The Humboldt County Medical Society met on the evening of December 2, 1937, at Eureka Inn, at 6:30 dinner.

The following officers were elected for 1938: Francis Stump, president; L. G. Kramar, vice-president; John A. Lane, treasurer; Lawrence A. Wing, secretary. Delegate, Allan Watson. Alternate, Lane Falk.

The papers of the evening were especially good. Dr. H. Glenn Bell spoke on *Acute Cholecystitis*, and Dr. Stacy Mettier on *Medical Aspects of Arthritis.*

The members enjoyed the visit of our State officers, Dr. Henry Rogers, Councilor, and Dr. Frederick Warnshuis, State Secretary. These officers gave a very excellent report on State Association activities and legislation.

Résumé of meetings for 1937:

President, Allan Watson.

Meetings held, 7; average membership present, 17; visiting speakers, 9; visiting State officers, 2.

After a very enjoyable evening the meeting adjourned.
LAWRENCE A. WING, *Secretary.*

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KERN COUNTY

The Kern County Medical Society met in regular session at the El Tejon Hotel in Bakersfield on Thursday evening, November 18, Dr. H. R. McAllister presiding. Dr. Lloyd Fox announced plans for the annual banquet to be given on December 18 at the Stockdale Country Club.

The following officers were elected for 1938: President, Dr. Harry W. Lange; Vice-President, Dr. H. A. Rivin of Delano; Secretary, Dr. C. S. Compton; Board of Directors, Dr. Peter J. Cuneo, Dr. L. A. Packard, Dr. Frank J. Gundry; Delegate, Dr. C. S. Compton; Alternate, Dr. Frank J. Gundry.

Because of the widespread interest in the problem of coccidioides infection in the San Joaquin Valley, the Society welcomed the opportunity of hearing Dr. Ernest C. Dickson of Stanford University, who was the speaker of the evening. Doctor Dickson spoke on the *Relation of Coccidoides Infection to "Valley Fever."* He asked the cooperation of the Society in the field study he has undertaken in the San Joaquin Valley. In spite of the great incidence of "valley fever" or so-called erythema nodosum in the Valley, it is only recently that its possible rerelationship to coccidioides infection has been investigated in Kern County, where a large number of affected patients are seen each year. The Society voted to coöperate with Doctor Dickson in his study in reporting all cases of "valley fever" and especially to aid in the bacteriological studies of sputum from the patients. Dr. Charles E. Smith, associated with Doctor Dickson in this investigation, spoke briefly on the plans and a number of slides illustrating the pulmonary findings in "valley fever" and in clinical coccidioidal granuloma infection were shown.

The meeting was adjourned, following which refreshments were served. C. S. COMPTON, *Secretary.*

PLACER COUNTY

The Placer County Medical Society held its regular meeting at the Freeman Hotel, Auburn, on December 11, 1937, with the president, Dr. C. E. Lewis, presiding. In addition to President Lewis there were present the following members and visitors:

Members—Doctors Kindopp, L. B. Barnes, Smith, Rood, Lundegaard, Thoren, Hummelt, Atkinson, Vinks, Hirsch, Russell, Peers, and Miller.

Visitors—Doctors Robert Stewart Peers, Herman V. Allington and Thomas I. Buckley, all of Oakland, and Doctor Ward of Auburn.

Following the reading of correspondence, the application of Dr. Edwin Slater Peeke was read for the first time.

Doctors Ray C. Atkinson and Daniel L. Hirsch presented a preliminary report for the Committee on Fee Schedule.

The president then introduced Dr. Thomas I. Buckley of Oakland, who presented a paper on *Urinary Antiseptics* in which he stressed culturing the urine and using mandelic acid therapy for the bacillary group, and sulfanilamid in small doses for the Streptococcus hemolyticus group. He also discussed other urinary antiseptics from their historical as well as their therapeutic efficiency.

Dr. Herman V. Allington of Oakland discussed *Eczematous Eruptions* and illustrated his talk with lantern slides. He pointed out that eczematous eruptions are characterized by red, infiltrated, blistering, weeping, crusting and scaling lesions, and by itching and burning. They may be due to external irritants (dermatitis venenata) or indirectly to internal organic disturbances, ingestion of drugs, and foci of infection. Allergy is an important consideration. In treatment one should first attempt to locate and remove the cause. Local medication should be primarily soothing and protective, with more active and stimulating remedies reserved for the chronic infiltrated forms.

Dr. Robert Stewart Peers, also of Oakland, presented a paper on *The Relation of Gall-Bladder Disease and the Rheumatic Syndrome*. This was a preliminary study of twenty-eight selected cases. These individuals were considered from their type of chronic arthritis and sedimentation tests and gastric complaints and age groups with the roentgenological findings by routine x-ray visualization. An outline of the care of these patients was also suggested.

These very interesting papers evoked considerable discussion.

Following adjournment, refreshments were served.

ROBERT A. PEERS, *Secretary*.

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SACRAMENTO COUNTY

The regular meeting of the Sacramento Society for Medical Improvement was called to order by President Raymond Wallerius on October 19, 1937, at the Auditorium on Twenty-ninth and L streets. There were fifty-nine members and guests present.

Doctor Wallerius reported on the case of a forty-year-old woman with osteomyelitis of the tibia, who has been going about town attempting to get morphin.

Speakers of the evening were members of our Society who had attended various clinics and medical congresses, both in the United States and abroad, during the past year.

Dr. O. S. Cook, in his talk, emphasized the method of treating carcinoma of the breast by preoperative x-ray up to 300 r at Adair's Clinic; and the method of doing biopsies by means of a long aspirating needle; the use of radium up to 9,000 milligram hours in the treating of carcinoma of the cervix at the Mayo Brothers Clinic; the treatment of carcinoma of the bladder by means of radium implants used at the Dean and Barringers Urology Clinic; and the treatment of carcinoma of the tongue by means of cones, which fit into the mouth, at the Hays Martin head and neck clinic.

Dr. Ralph Graham spoke on the International Congress of Radiologists at Chicago. The essential points stressed by Doctor Graham were the effect of x-ray on the healing of wounds; the use of x-ray therapy in treating infections, bites, furuncles, carbuncles, cellulitus; and the good results from the use of x-ray in the treatment of lobar pneumonia. The use of x-ray therapy in bronchiectasis and gas-gangrene infections was also suggested.

Doctor Hale told about his experiences and type of work seen at the various European clinics visited; the modern hospitals in London; the use of avertin intravenously by the drop method over a period of hours, as seen at Leningrad, Russia; the use of intravenous diatrast for diagnosis as the only method used in Moscow; and the work on tuberculosis of the kidney as seen in Weilderbold's Clinic in Switzerland. Doctor Hale remarked about the absence of prostatic resections in Europe.

Dr. G. J. Hall spoke on female endocrinology and new hormones, as taken up at the meeting of the Society for the Study of Internal Secretions. Prolactin, a milk forming hormone, and its effect on endometrial hyperplasia was discussed. Doctor Hall stressed the danger in using prolactin for the production of milk because of its action in reducing the function of the ovaries.

Doctor Rulison told of his visit to the International Congress of the Radiologists at Chicago, and was most impressed by the excellent life-size models on diaphragmatic hernia and pictures of the surgery on that type of hernia. Harrington's results on surgical treatment at the Mayo Clinic were discussed, as well as the symptoms found in cases of paraesophageal hernia.

Dr. Hilding R. Johnson showed some excellent motion pictures taken while on his Alaskan trip.

The applications for new membership of Doctors Roscoe Clark, James Yant, Aaron Gourse, Adrian Crossen, and Godfrey Steinert were voted upon and all were elected to membership. The application of Dr. R. O. Schofield for membership by transfer was read for the first time.

Doctor Dozier announced the meeting of the Northern District Medical Society at the Elks Club on November 6.

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The regular meeting of the Sacramento Society for Medical Improvement was called to order by the President Raymond Wallerius on November 16, 1937, at the Auditorium on Twenty-ninth and L streets. There were sixty-three members and guests present.

Dr. L. Taussig of the University of California Medical School presented the first paper of the evening. He discussed *Dermatological Conditions Associated with Diabetes Mellitus*. Doctor Taussig first discussed the relation between the high glucose content of the skin in diabetes and its relation to skin infections. That the amount of sugar in the skin is definitely increased with and increase in blood sugar has been proved experimentally; but there apparently is no proof so far that this causes an increase in susceptibility to skin disease. Doctor Taussig then took up the skin conditions most commonly associated with diabetes, *i. e.*, eczema, chronic urticaria, pruritus, purpura, gangrene, and xanthoma. The roll which diabetes plays in such cutaneous infectious as furunculosis, dermatophytosis, and pruritus, is not known. The paper was concluded by showing lantern slides of some of the cases discussed.

The second paper of the evening was presented by Dr. H. C. Shephardson, who spoke on the *Use of Prolonged Acting Insulins*. Doctor Shephardson opened his discussion by stating that one-half per cent of all the people are afflicted with diabetes, and that one per cent of all the people die of the disease. In comparing the two insulins now in use, it has been found that the maximum effect of regular insulin is attained in three to four hours, whereas the protamin insulin attains its maximum effect in twenty-four hours and acts over a period of seventy-two hours. Protamin insulin has a cumulative effect, and hence the danger of producing a state of hypoglycemia slowly in the patient, with resultant permanent mental changes. This appears to be the main danger in its use. The main contraindications to the use of protamin insulin are (1) infections, such as gangrene and septicemia; (2) treatment of coma. Protamin insulin acts too slow in these cases. Protamin insulin is of the utmost value in children where the number of injections can be cut down greatly, and as a result enables the physician to control these diabetic children without the use of the needle so often. Doctor Shephardson next mentioned the new U80 protamin insulin which is now on the market, and a new crystalline insulin which will soon be available.

The discussion on the papers was opened by Doctor Scatena and continued by Doctors E. Sevier, Frank Lee, and Aaron Gourse.

The application for membership, by transfer, of Dr. R. O. Schofield was read for the second time and voted upon. He was elected to membership unanimously.

Dr. F. F. Gundrum asked that the Society take up the matter of the old minutes of the Society, and stated that he felt these old records should be preserved in a safe place for their historical value. A motion was made and so passed that the officers of the Sacramento Society for Medical Improvement arrange to deposit all such minute books in the State Library in the California section.

Dr. J. B. Harris requested the Board of Directors to take up the matter of a uniform listing of physicians in the telephone directory (classified section).

G. E. MILLAR, *Secretary.*

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SAN BERNARDINO COUNTY

The regular meeting of the San Bernardino County Medical Society was held at the San Bernardino County Charity Hospital on Tuesday, December 7, 1937, at 8 p. m. The meeting was called to order by the president, Dr. D. B. Williams. About sixty members and guests were present.

The application of Dr. Kenneth E. Kellogg of Loma Linda was favorably voted on.

Dr. Lowell Goin, Speaker of the House of Delegates of the California Medical Association, presented facts regarding the medical economic survey made by the California Medical Association some four years ago, and also discussed the *Principles and Proposals* brought about by the *Committee of Four Hundred and Twenty* and stressed a united front by the profession, regardless of an occasional individual's feeling in the matter.

The program of the evening was given as follows: *The Use of Convalescent and Normal Human Serum in the Treatment of Disease* by Dr. Hugh K. Berkley of Los Angeles; *The Convalescent Serum Center and Its Value to the Community* by Dr. C. M. Hyland of Los Angeles.

Informal discussion and questions followed.

The meeting adjourned at 10 p. m., following which refreshments were served.

ARTHUR E. VARDEN, *Secretary.*

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SAN FRANCISCO COUNTY

The annual report of President T. Henshaw Kelly follows:

The Board of Directors of your Society held its usual regular meetings throughout the year and special meetings on May 24 and September 8, 1937.

During the year, invitations were issued by the Board to the American Medical Association, the American Association of Military Surgeons, and the International Society for Crippled Children, to hold annual meetings in San Francisco. The American Medical Association, as you know, will meet here, beginning June 13, 1938.

The Board considered the matter of blackface type advertising in the telephone directory and requested all members of the county society who indulge in this type of listing in the telephone book to discontinue it, as it is against the policies set up by all principles of ethics.

The matter of speaking before lay groups in other counties by our members was also brought before the Board by the component societies of other counties, who objected to some of the talks thus given. The Board, in justice to other county societies, who cannot control our members, ruled that no member of this Society shall go into another county to talk before a lay group, without receiving the permission of the component county society of the county in which he intends to speak. It has been suggested that a committee be appointed whose duty it shall be to pass upon the fitness of any intended speech by a member to a lay group in the City and County of San Francisco.

Nineteen hundred and thirty-seven saw a biennial meeting of the legislature, and foremost in that session was again the matter of health insurance, activity being along two lines—one by the California Medical Association, designed to permit the physicians of any county to organize and operate a health insurance association; and the other, by existing illegally operating agencies, to legalize themselves and to permit the formation of other loosely organized and supervised agencies. Many of our members gave of their time and effort to further the purposes of the Association, but the legislature adjourned without enacting such legislation.

A move by the Farm Bureau and others to legalize the opening of county hospitals to pay patients was defeated.

The Board approved a bill to prevent untrained and unlicensed laymen from setting up diagnostic and therapeutic x-ray laboratories. This bill was presented to the legislature, passed and pocket-vetoed by the Governor.

On November 30, the Society gave a dinner to Dr. Morris Fishbein, who spoke on the present trends in medical economics in the country. The dinner was attended by 260 members of the San Francisco and other Bay counties societies.

During the year the Society approved a proposed amendment to the Charter designed to remove the office of the Director of Public Health from politics. However, this proposed amendment did not reach the ballot.

It approved the bond issue on the last ballot to provide for improvements at the County Hospital and the Laguna Honda Home, and this was one of the few issues passed by the voters.

Because he is a physician who has devoted himself, as a Supervisor, to assisting medicine and its aims in the City and County government, the Board endorsed the candidacy of Dr. Adolph Schmidt for Supervisor. He was elected.

The Committee on Malpractice Insurance—Doctor Gilman—has done an immense amount of work this year to keep abreast of the changes in malpractice insurance policies which have taken place during the year.

Yearly the coverage and cost of this insurance are decreasing and increasing respectively, and the field has been confused by the appearance of a large number of types of policies written by Lloyd's of London, practically no two of which are alike and many no good. The American companies still writing this insurance have decreased their coverage and increased their costs, and Doctor Gilman is preparing a short report of the present situation, which is to be published in the *Bulletin* either in January or February. Every member should read this and should carefully investigate the actual coverage that his present malpractice policy gives him.

Finally, we come to the matters dealing with the economics of medical practice that have come before the Board during the year.

Previous to 1937, the Shell Oil Company had endeavored to establish a fee schedule and panel of physicians to care for its employees in and about San Francisco. After discussion, argument and distress produced by publication of letters in the *Bulletin*, during this year the Shell Benefit Fund has paid members of this Society for their care of Shell employees and have done so on the basis of their reasonable charges rather than on a panel fee schedule. We hope it will keep on.

The Pacific Employers Insurance Company has recently completed, in conference with a committee of the Board of Directors of your Society, a policy form providing indemnity for medical and hospital costs which is in all ways satisfactory to your Board of Directors. It is indeed an encouraging sign when a company of this standing asks the help and coöperation of the Society in the formulation of such a policy.

The year has seen the establishment of the Insurance Association of Approved Hospitals in San Francisco. As you know, in order that we might have a unified hospital service plan in the Bay region, the San Francisco Society, instead of starting an independent organization, approached this Association in Alameda County and the hospitals in San Francisco County, and an agreement was reached whereby the Insurance Association of Approved Hospitals and nine San Francisco hospitals signed contracts, opened a San Francisco office and began to sell hospitalization insurance policies. Representation of San Francisco medicine and hospitals will be given on the Board of the Approved Hospitals, and the whole project has been worked out harmoniously and effectively. The other Bay region counties have joined in, and the one organization can take contracts for the whole Bay region. The Board appropriated $1,000 to use for promoting the start in San Francisco.

This accomplishment is due, for our part, to the Committee on Health and Hospitalization Insurance, consisting of Drs. Karl L. Schaupp (chairman), J. Marion Read, and Rodney A. Yoell. The Society owes these members its

thanks for their unremitting effort and uncounted hours of time spent in this work and in the other project that came within their purview.

That project is the Health Service of the City Employees of the City and County of San Francisco. As most of you know, this was conceived by the Federation of Municipal Employees, and a proposed amendment to the Charter was presented to the Board of Supervisors in late December for placement on the ballot in the spring election. The terms of this proposed amendment were very objectionable to us and, despite the fact that the Federation's representatives laughed at our committee when it said we would not accept them, we succeeded, with the hospitals, dentists, druggists, grocers, and other interested parties, in so amending the amendment in the Board of Supervisors that it required the Health Service Board, created by the amendment, to provide free choice of physicians, hospitals and other agencies of medical care, and to present, for approval to the Retirement Board any contract or schedule of fees under which it proposed to operate any health service plan.

The Board of Directors of your Society then approved this Charter Amendment. It was passed by the voters, and the city employees then proceeded to elect a Health Service Board under the terms of the Charter Amendment.

This Board then proceeded to dilly dally with our committee for months in an attempt to get from it a fee schedule which it could promulgate as our fee schedule, but the committee refused any schedule except as an integral part of a worked-out plan.

The Health Service Board then signed a contract with the Sutter Hospital group, hired three physicians to make up a fee schedule and then presented these two matters to the Retirement Board for its approval. After four hearings, at which our committee and legal counsel appeared, as well as representatives of the hospitals, nurses, pharmacists, etc., the Retirement Board disapproved both the contract and the fee schedule.

The Health Service Board is now working on some other plan and is to meet with our committee tomorrow night, at which time our committee will present a plan, authorized by the Board of Directors, as a basis for the development of a working agreement. What the outcome of this will be, we do not know. We are anxious to work with the Health Service Board, for whatever develops from this Amendment will doubtless be a pattern for other communities, and we should like to develop a plan that will provide the best of care without undermining the basic tenets of medical practice. So far, coöperation has not been the outstanding characteristic of the Health Service Board, or at least, of some of its members.

It has been a busy year. In practically my last words as president I want to thank you all for my office. I have enjoyed it and hope that I have justified the choice.

More do I want to thank those who worked with me, pleasantly and so faithfully, to carry out those things which presented themselves for doing. T. HENSHAW KELLY.

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SAN JOAQUIN COUNTY

The annual meeting of the San Joaquin County Medical Society was held on December 2 in the Walnut Room of the Hotel Clark. The meeting was called to order by President John Blinn. A very excellent dinner was served.

The petition of Dr. H. E. Schwing of Standard, California, was read and referred to the Admissions Committee.

The annual report of the secretary-treasurer was read and approved. It was moved by Dr. D. Powell, seconded from the floor, that the secretary-treasurer be given a vote of thanks for the splendid work done in 1937. The motion was carried.

Dr. C. A. Broaddus read a report of the Postgraduate Committee.

There was considerable discussion from the floor concerning the attempts of the National Automobile Insurance Company to have practitioners in this county rebate 25 per cent of their fees to this company. It was moved by Doctor Van Meter that the San Joaquin County Medical Society be placed on record as unalterably opposed to fee splitting or reduction of fees or rebating of fees to the National Automobile Insurance Company; that a copy of this resolution be mailed to all members of the San Joaquin County Medical Society and the National Automobile Insurance Company; and that any member accepting work from any insurance company entailing reduction of fees, splitting of fees, or rebating of fees, be referred to the Committee on Ethics and Professional Conduct for such disciplinary action as the Committee sees fit." This was seconded by Dr. C. V. Thompson. The motion passed.

The following are the results of the election, reported by the Elections Committee:

A. C. Boehmer, president; N. P. Barbour, first vice-president; F. A. McGuire, second vice-president; G. H. Rohrbacher, secretary-treasurer.

Directors—G. H. Sanderson, H. C. Chapman, C. V. Thompson, C. A. Broaddus, J. F. Blinn, D. Powell, and J. F. Doughty.

Delegates—D. Powell, G. H. Sanderson, and J. F. Doughty.

Alternates—C. A. Broaddus, G. H. Rohrbacher, and C. V. Thompson.

The paper of the evening was presented by Dr. Phillip King Brown of San Francisco, who spoke on *These Changing Times in Medicine: With an Interpretation of Some Observations on Medical Practice in Mexico.*

There being no further business to come before the Society, the meeting was adjourned at 10:45 p. m.

G. H. ROHRBACHER, *Secretary.*

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SHASTA COUNTY

The Shasta County Medical Society had its last meeting at the Hotel Redding on November 15, 1937. The meeting was called to order by President O. J. Hansen.

The fact that there were three cultist practitioners recently arrived in Redding for the purpose of practicing, and the fact that they were allowed to practice surgery and medicine in the St. Caroline Sanitarium, caused the following motion to be brought up and passed:

"That the Shasta County Medical Society go on record to discountenance the aiding, abetting, assisting, or employing any person who professes to practice a system of treatment of the sick other than regularly licensed doctors of medicine, graduates of approved medical schools, by any member of the Shasta County Medical Society. Any member violating this rule will be expelled from the Society in accordance to his agreement in entering the Society."

Members present were: Doctors Hansen, Seeley, Olberg, Pratt, Kay, and Dozier. Guests were: Doctors Murphy and Falk. LESLIE J. SEELEY, *Secretary.*

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SOLANO COUNTY

A regular annual meeting of the Solano County Medical Society was held at the Casa de Vallejo Hotel at 8:30 p.m. December 14, 1937, the meeting being called to order by President Perkins.

A motion was passed that members of the Society prescribe no drugs except those accepted by the American Medical Association, and that CALIFORNIA AND WESTERN MEDICINE be requested to print a list of new and nonofficial remedies periodically. Motion carried unanimously.

The secretary was instructed to write a letter to Senator Hiram Johnson and one to Congressman Buck, urging them to vote for a revision of the Pure Food and Drug Act which would shortly be introduced in Congress. The secretary was instructed to sign the names of all members of the Society to this letter.

The secretary asked the older members whether they could remember seeing a charter for the County Medical Society at any time during the Society's history. Doctor Peterson and Doctor Leachman, who were the oldest members present, could remember no charter having been presented to the Society. A Constitution Committee is to be appointed by the incoming president to revise our present Constitution.

Dr. Johann Couperous of Rio Vista was accepted as a member of the Society by unanimous vote.

A motion was made by Doctor Parks and seconded by Doctor Finan that meals reserved at our monthly dinners which are not cancelled before the meeting shall be billed to the member making the reservation. Unanimously carried.

Election of officers resulted as follows: Dr. Ream S. Leachman, Vallejo, President; Dr. Milford Bransford, Vallejo, Vice-President; Dr. John W. Green, Vallejo, Secretary-Treasurer; Delegate, Dr. John W. Green; and Alternate, Dr. D. B. Park.

The same Board of Censors will continue to serve until a new Constitution is presented and approved.

A report was made by the secretary on the address made by Dr. Morris Fishbein, Secretary of the American Medical Association, which was delivered at San Francisco at the Palace Hotel on the evening of November 30.

The secretary also discussed the final report of the California Medico-Economic Survey, stressing certain points made in the informal comments concerning possible interpretations and conclusions to be drawn from the factual data, and also commended the good sense of the Official Committee on Publication consisting of Dr. Howard Morrow, Dr. Edward Pallette, and Dr. George Kress.

The Society was once more invited to become more familiar with CALIFORNIA AND WESTERN MEDICINE.

The Committee on Post-graduate Study, Dr. A. V. Doran, Chairman, and the committee which was appointed to meet with the women's clubs, were discharged with thanks for past services.

The secretary discussed the recent study made by the Solano County Institutions Committee, appointed by the supervisors with a view to better medical service for our indigents without increased costs to the taxpayers, and suggested that a revolving staff for the County Hospital to serve without pay might be an advisable step.

Proposals for medical defense were then taken up and applications for membership in the Medical Society of the State of California were presented to each member and they were encouraged to remit $10 to the Society for legal defense in case of suits for malpractice. It was also brought out that a policy written by Lloyd's of London was available through the firm of Newhouse & Sayer which supplied indemnity of from $50,000 to $150,000 for approximately $55 per year. Attention was also called to the fact, that because there were many so-called "Lloyd's Policies," some with and others with less merit, that before signing up, it was advisable to write to the central office of the California Medical Association for further information.

JOHN W. GREEN, *Secretary.*

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VENTURA COUNTY

The regular monthly meeting of the Ventura County Medical Society was held at the Saticoy Country Club on Tuesday, November 9, 1937.

Members present were: Doctors Hendricks, Coffey, C. A. Smolt, Shore, Mosher, Bardill, Drace, Gronhovd, Barker, and Morrison. Guests were: Doctors Pressman, Hirchfield, Kuffel, Garrett, Moore, and Witten.

Dr. J. J. Pressman of Los Angeles presented moving pictures of the larynx and vocal cords in normal and pathologic states. The members present expressed great interest in these pictures.

It was decided that the December meeting would be given over to the annual election of officers.

A. A. MORRISON, *Secretary.*

CHANGES IN MEMBERSHIP

New Members (18)

Alameda County

David Hadden

Los Angeles County

Alfred Fellows
Stuart C. Knox
Monte Salvin

Riverside County

Lawrence H. Hall
Hudson H. Martin

Sacramento County

Aaron Gourse

San Diego County

Gilbert F. Harris
Kerwin W. Kinard

San Francisco County

John E. Bohm, Jr.
Adena C. Dutton
William M. Fitzhugh
George Bernhard Miller

Shasta County

Morton J. Murphy

Yolo-Colusa-Glenn County

Albert R. Egan
Lloyd R. Hennig
Hugh M. Simmons
Max A. Waters

Transferred (4)

W. H. Barnes, from Alameda County to Butte County.

Elmer M. Bingham, from Riverside County to Yolo-Colusa-Glenn County.

John B. Hollingsworth, from Yolo-Colusa-Glenn County to Alameda County.

Richard O. Schofield, from Placer County to Sacramento County.

In Memoriam

Fehliman, William Edward. Died at Portland, Oregon, November 25, 1937, age 57. Graduate of Rush Medical College, University of Chicago, 1906. Licensed in California in 1919. Doctor Fehliman was a member of the Santa Cruz County Medical Society, the California Medical Association, and the American Medical Association.

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Hull, Leonard Charles. Died at Hollister, November 26, 1937, age 67. Graduate of Cooper Medical College, San Francisco, 1893. Licensed in California in 1894. Doctor Hull was a member of the San Benito County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Rea, Thomas. Died at Yreka, December 1, 1937, age 57. Graduate of Oakland College of Medicine and Surgery, 1913, and licensed in California the same year. Doctor Rea was a member of the Siskiyou County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Styan, William Earnshaw. Died at San Francisco, November 24, 1937, age 63. Graduate of the College of Physicians and Surgeons, San Francisco, 1906. Licensed in California in 1909. Doctor Styan was a member of the San Mateo County Medical Society, the California Medical Association, and a Fellow of the American Medical Association.

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Wall, Albert Samuel. Died at Los Angeles, September 9, 1937, age 76. Graduate of Miami Medical College, Cincinnati, Ohio, 1890. Licensed in California in 1917. Doctor Wall was a retired member of the Los Angeles County Medical Association, the California Medical Association, and the American Medical Association.

OBITUARY

William Edward Fehliman

1879–1937

A motor accident while returning to his home from his favorite recreation, elk hunting, caused the death of Dr. William E. Fehliman, one of the best known and loved of Santa Cruz physicians, on November 24, 1937.

William E. Fehliman was born near Sedan, Indiana, on September 16, 1879. His family soon moved to Nebraska and his boyhood was in that state. After an academic course at the University of Chicago a medical career was begun at Rush Medical College, from which he was graduated in 1906. Following an internship at Cook County Hospital, Doctor Fehliman entered practice at Lead, South Dakota, and continued at that place until entering the

service of his country in 1917. While in Lead Doctor Fehliman was married to Lola Inez Shackelford, who now survives. From 1917 to 1919 Doctor Fehliman served as captain in the Army Medical Corps, being attached to the New York 77th Division, the greater portion of his army career being at the front in France.

Following the war, Doctor Fehliman came to Santa Cruz in 1917 and associated himself with Dr. Stanley W. Dowling in the practice of medicine. During his years of practice in Santa Cruz Doctor Fehliman gained the respect and confidence of the community. His ability and tireless efforts in the behalf of those in need were appreciated not only by his patients, but also by those who knew him only as a friend. His untimely passing is a distinct loss to the community of Santa Cruz.

Doctor Fehliman was a member of the Santa Cruz County, California, and American Medical Associations.

SAMUEL B. RANDALL, M.D.

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John Randolph Haynes
1853–1937

October 30, 1937, recorded the death of Dr. John Randolph Haynes, age 84.

Doctor Haynes was born at Fairmont Springs, Pennsylvania, June 13, 1853; he received his M.D. degree from the Medical School of the University of Pennsylvania in 1874. Was in private practice in Philadelphia until the year 1887, at which time he came to California.

Two years later he became a member of the faculty of the then College of Medicine of the University of Southern California, as associate professor of gynecology .

Some years ago Doctor Haynes practically retired from private practice.

In CALIFORNIA AND WESTERN MEDICINE of July, 1937, on page 37, appeared a photograph of Doctor Haynes and a brief article containing newspaper excerpts made on the occasion of his eighty-fourth birthday.

From the Los Angeles *Examiner:*

Dr. John R. Haynes, the "grand old man of municipal ownership" in Los Angeles, blew out the candles on his birthday cake in the quiet parlor of his Figueroa Street home yesterday and settled back in his chair to talk of his fifty years in the city and of things to come in the next fifty years.

He was eighty-four years old. During the last half-century, as a liberal whose faith would not fail, he had served his city, his state, and his country; his creed, democracy, and his cause, municipal ownership. Since 1921 he had served as a member of the Water and Power Commission. . . .

The achievement Doctor Haynes finds most pride in was the writing into the California Constitution of the initiative, referendum, and recall, California being the first state to adopt these measures, which were considered ultra-liberal at the time of their proposal.

The Los Angeles *Herald-Express*, in an article concerning Doctor Haynes, reported as follows:

Bequeathing the bulk of his estate to the cause of promoting the well-being of mankind, particularly the working people, the will of Dr. John R. Haynes, civic leader, philanthropist and president of the Los Angeles Water and Power Commission, was filed on October 15.

This humanitarian work, the will provides, shall be carried out through the trustees of the John Randolph Haynes and Dora Haynes Foundation, which was created by Doctor Haynes and his wife in September, 1926.

While Doctor Haynes had been reputed to be a millionaire, it was stated that in recent years he and his late wife, Dora Haynes, had given away large sums for charitable purposes and that the property remaining probably would amount to less than a million dollars, but more than $500,000. Doctor Haynes died last Saturday at the age of eighty-four.

After a number of bequests to relatives, the will bequeathed the residue to the Foundation. This residue, with large endowments made by Doctor Haynes and Mrs. Haynes since its organization, will give the Foundation a working capital of approximately one million dollars, it was reported today.

THE WOMAN'S AUXILIARY TO THE CALIFORNIA MEDICAL ASSOCIATION†

MRS. HOBART ROGERS ..... President
MRS. FRED ZUMWALT ..... Chairman on Publicity

News Letter

Dear Auxiliary Members:—The holidays are now over and I hope that, for each and all of you, they were pleasant ones. You will be delighted to know that when Christmas gifts were being distributed the Auxiliary was not forgotten. *A present of two new counties!* That is what your State Chairman of Membership and Organization, Mrs. Frederick N. Scatena of Sacramento, has given to you. These two counties are Butte and Santa Cruz, and they are splendid and welcome additions to a splendid organization. With the acquisition of these counties we now have all (those that are more thickly populated) of the larger counties organized. This is a very fine record for the short period that the Auxiliary has been in existence in the State of California—eight years, to be exact. But let us not be satisfied until *every county* is organized and *every woman* who is eligible a member.

Both of these recently formed counties have already sent in reports of their organization meetings. They are printed just below in this issue; be sure to read them. Personally, I wish to thank them for their prompt coöperation.

The goal of our president when she took office was a 100 per cent membership, and some of the counties are helping her to attain it. Mrs. Rogers' own Auxiliary, Alameda County, has taken in over thirty-two new members in less than two months. Los Angeles County has signed up, in one month's time, sixty-one new members! And "lest we forget," Marin County has a membership of thirty-seven and there are but thirty-nine eligible women in the county.

If any of the other counties have reports of this kind to give, please send them in, for "nothing succeeds like success."

Sincerely yours,

MRS. FRED H. ZUMWALT.

Component County Auxiliaries

Alameda County

Members of the Alameda County Auxiliary met on Friday, November 19, 1937, at luncheon in the dining room of the Claremont Country Club. The meeting that followed was in the Lounge. As usual, an informal half-hour of reception, presided over by Mrs. George Reinle. preceded the affair. Reservations were in charge of Mrs. O. T. McAllister.

Reports of board members' activities were given at the business meeting, at which the president, Mrs. A. A. Alexander, presided. Mrs. Harold Trimble, state chairman of *Hygeia,* in an interesting and stimulating talk, told of this publication of the American Medical Association and urged each member to see that it be placed in at least one home this Christmas. Mrs. W. H. Sargent, past president of both the Alameda County and California State Auxiliaries, also spoke on the value of *Hygeia,* and then gave a short report of the work done by the Auxiliary's Battalion in the Community Chest drive. We were proud to hear that our workers had gone over the 100 per cent mark set for us.

Dr. Benjamin Black, Director of Alameda County Institutions, was the honored guest. His subject was relative to his work as a public health director. As he is one of

† As county auxiliaries of the Woman's Auxiliary to the California Medical Association are formed, the names of their officers should be forwarded to Mrs. Fred Zumwalt, Chairman of the Publicity and Publications Committee, 3880 Clay Street, San Francisco. Brief reports of county auxiliary meetings will be welcomed by Mrs. Zumwalt, and must be sent to her before publication takes place in this column. For lists of state and county officers, see advertising page 6. The Council of the California Medical Association has instructed the Editor to allocate two pages in every issue to Woman's Auxiliary notes.

our most popular and delightful speakers, the attendance was large; many expressed the wish that we have the privilege of hearing Doctor Black more often.

The next meeting of the Auxiliary will be held at the Claremont Country Club in January, at which time a very fine program of both medical and cultural interest will be presented.

Our membership now totals 292! We are happy to welcome the following members: Mesdames E. W. Page, T. C. McCleve, Hewitt Robinson, J. T. Harkness, Erwin Epstein, Fred Fisher, Gale Whiting, W. W. Nicholson, Floyd Lewis, W. E. Hart, R. G. Libby, R. J. Walker, Ronald W. Troup, W. S. Williams, E. J. Jakemy, C. E. Cocks, Don Manley, P. H. Miles, and E. M. Grimmer.

MRS. GRANT ELLIS,
Chairman of Publicity.

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Butte County

Wives of the members of the Butte County Medical Society met on Tuesday, November 9, 1937, relative to forming a Woman's Auxiliary.

Mrs. Frederick N. Scatena of Sacramento, First Vice-President of the State Auxiliary and State Chairman of Membership and Organization, was the guest of honor and gave an interesting talk, telling of the need and value of the Auxiliary organization throughout the state and nation. She spoke of the success and organization history of her own county, Sacramento.

After the address by Mrs. Scatena, a short business meeting was held at which initial plans of organization were formed and the following officers elected: Mrs. J. H. White of Chico, president; Mrs. W. H. Barnes of Chico, vice-president; Mrs. J. H. Alexander of Chico, secretary; Mrs. L. A. Jacoby of Oroville, treasurer. The directors are: Mesdames N. T. Enloe, C. C. Landis, J. H. Fabrian, and J. G. Hepplewhite.

At the conclusion of the meeting, tea was served.

MRS. J. H. WHITE,
President.

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Los Angeles County

The Woman's Auxiliary to the Los Angeles County Medical Association met for luncheon on November 23, 1937, at the County Medical building, Mrs. Eliot Alden presiding.

A group of songs was rendered by Miss Martha Friedberger. Mrs. Robert Heffner gave a most interesting talk on her work as referee at the Juvenile Hall. Medical highlights were presented by Mrs. Karl von Hagen.

The Philanthropy Committee, in charge of Mrs. Harold E. Crowe, had asked for contributions of canned food for the Thanksgiving baskets, and they were collected at this meeting. This committee functions at holiday seasons, distributing staple foods, fruit, candies, and magazines to the families of a few needy doctors in the county.

MRS. ROBERT L. CARROLL,
Corresponding Secretary.

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Marin County

A very enjoyable luncheon meeting was held on Thursday, November 18, 1937, at the Alta Mira Hotel in Sausalito. There were twenty-one present.

Mrs. Furlong announced that there was a contest on for *Hygeia*. It was decided that the Auxiliary should have a card party to raise funds for subscriptions to *Hygeia*. Mrs. G. Landrock was appointed committee chairman. Her committee members are Mesdames Marston, Miller, Hawkins, and Robinson.

Mesdames Polland, Hazeltine, Fowler, Robertson, and Conroy were appointed as a new committee to determine the philanthropic work of the Auxiliary.

Mrs. Hobart Rogers, State President, and our first guest speaker, was then introduced. Mrs. Rogers gave us a brief and inspiring talk on the purpose and ideals of the organization. She mentioned the many things that it had accomplished and the hopes that she had for its future.

Mrs. Charles Hall, State Corresponding Secretary, then thanked Marin County for its coöperation and urged us to keep up the good work.

Miss Edith Waterman, Chairman of the Red Cross in San Rafael, was then introduced and told of the numerous services the Red Cross had rendered during the year. She suggested that the Auxiliary might assist the Red Cross in establishing emergency stations along the highways, or it might help in maintaining a list of registered donors to be called for immediate blood transfusions. Sending wheelchairs and hospital beds would be a great help. She also suggested that assistance in the development of the Braille program for the blind was needed.

There was no further business and the meeting was adjourned.

MRS. R. B. HARTMAN,
Chairman of Publicity.

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Riverside County

The November meeting of the Woman's Auxiliary to the Riverside County Medical Society was held at the home of Mrs. C. N. Callander, with Mrs. Ratliff and Mrs. Wayland Coon as cohostesses.

Dr. and Mrs. Olsen of San Bernardino presented a program, descriptive of their recent European tour. This was illustrated with motion pictures. Mrs. Erwin Miller told of a trailer trip taken during the summer, and Mrs. Arthur W. Walker described vividly a visit she had made to the famous "quints."

The members seem most enthusiastic, and we expect to have an enjoyable and profitable year.

KATHARINE L. WICKMAN,
Corresponding Secretary.

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Sacramento County

About forty members of the Woman's Auxiliary to the Sacramento Society for Medical Improvement met at the home of Mrs. E. O. Brown on Tuesday evening, November 16, 1937.

Mrs. Donald R. Benson gave several vocal selections, accompanied by Mrs. Zue Geary Pease. Bridge occupied the remainder of the evening. A buffet supper was served.

Joining Mrs. Brown as hostesses were: Mesdames Albert Almada, Harry Baird, H. H. Beauchamp, W. H. Davis, Walter Hicks, Frank Krull, and D. L. McLean.

MRS. HUGH CARMICHAEL,
Chairman of Publicity.

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Santa Cruz County

Our first meeting—the organization meeting—of the Woman's Auxiliary to the Santa Cruz Medical Society was held at the home of Mrs. Alfred L. Phillips on Thursday, November 18, 1937.

Mrs. F. N. Scatena of Sacramento was guest speaker, and told us of the purposes and advantages of the Woman's Auxiliary.

The following officers were elected: Mrs. Alfred L. Phillips, president; Mrs. H. G. Watters, first vice-president; Mrs. N. R. Sullivan, second vice-president; Mrs. Gordon Bunney, corresponding secretary; Mrs. R. C. Alsberge, recording secretary; Mrs. W. E. Fehliman, treasurer. The directors are: Mesdames A. N. Nittler, to be in charge of programs; O. C. Marshall, to be in charge of the educational work that is to be planned; J. D. Fuller, who will be responsible for the work at the County Hospital; Mrs. D. S. Woodward will act as hostess.

Our regular meetings will be held on the second Monday of each month at the Rio Del Mar Country Club.

MRS. R. C. ALSBERGE,
Chairman of Publicity.

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San Diego County

The Woman's Auxiliary to the County Medical Society was particularly favored on Tuesday, November 9, 1937, in being permitted to view a portion of Dr. George Huff's

colored films taken during his recent trip abroad. His illustrated lecture, entitled *Russian Medicine*, emphasized the very drab, delapidated, and rundown conditions of buildings and equipment in Russia.

Doctor Huff illustrated very clearly the low standard of living, the impoverished appearance of all people in the Russian streets, the lack of transportation facilities, the hopeless, dejected expressions of the old and young alike. He showed many street scenes in which automobiles were a rarity. Only officials possess cars in Russia. One doctor, who had rendered great service, was permitted an automobile with two chauffeurs. His use of the car usually included about thirty miles a week, every movement and call being carefully reported by the chauffeurs to the government. The doctor was not permitted to use the car for personal pleasure at any time.

Doctor Huff called attention to the need for doctors in Russia. The Soviet Government is now giving the medical students a salary while attending school.

He states that medical work in Russia is organized under various departments. The obstetrical department is headed by a most remarkable woman. Stalin recently sent an order to her, stating: "Eliminate venereal diseases." This was a large order, but the doctor ordered treatment for every infected person, and a legal statute has made it a criminal offense, punishable by not less than eight years in prison, for any person to transmit the disease. Prostitutes are examined every two weeks. Venereal diseases have not been eliminated, but great material progress has been made.

The equipment of all hospitals in Russia is extremely poor. The nurses are poorly dressed, with no stockings whatever. The rooms look bare and badly in need of repair.

However, in the field of obstetrics, Russia has made some remarkable progress. In other countries of Europe, midwives deliver many of the babies, but in Russia it is a law that all babies must be born in the hospital, and doctors are legally responsible for getting their patients to the hospital in time for delivery. The mothers are cared for and given pay during pregnancy and for a certain period after the birth of the child.

After visiting clinics all over Europe, Doctor Huff states that he believes America to be far ahead of all European countries in the field of medicine.

On December 14, Mrs. E. A. Blondin presented a book review to the Auxiliary.

On November 20, the annual dinner dance of the Auxiliary was enjoyed at the U. S. Grant Hotel in the Plata Real. It proved to be a most enjoyable occasion.

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San Francisco County

Honoring our state president, Mrs. Hobart Rogers, members of the Woman's Auxiliary to the San Francisco County Medical Society and guests gathered at a formal tea on Monday, November 29, 1937, at headquarters, 2180 Washington Street.

Presiding at the tea table were Mesdames Thomas Gibson and Julius Sherman, assisted by Mesdames J. V. Leonard and Lewis Michelson. Among the state officers who attended were Mesdames Harry C. Hund, Harold Trimble, and Charles C. Hall. Auxiliary presidents of neighboring counties were Mesdames A. A. Alexander of Alameda and Thomas Gocher of Marin.

Decorations for the tea table and rooms, in autumn foliage, fruits and vegetables, were beautifully arranged by Mrs. John D. Humber. A travel film of Mexico was shown at 2:30, preceding the tea.

Mrs. A. S. Musante, Chairman of Arrangements, was assisted by Mesdames George H. Becker, Anthony B. Diepenbrock, Howard B. Dixon, Arno G. Folte, John D. Humber, Otto Laist, Edmund J. Morrissey, William W. Newman, Harry R. Oliver, Frank Rodin, and Stuart C. Way. Members of the receiving line were: Mesdames Hobart Rogers, Fred H. Zumwalt, A. S. Musante, Harry C. Hund, William Sargent, and Thomas J. Clark, Jr. Our president, Mrs. Hans Barkan, was absent on account of illness.

Mrs. Rogers made an official visit to the Auxiliary at the regular meeting on November 16, at which time she gave a most inspiring talk. The purposes of our organization were clearly outlined, and the importance of the membership supporting the county, state, and national auxiliaries emphasized.

As guest speaker for the November meeting, Dr. Harold K. Faber delivered an interesting address on the *Recent Advances in Our Knowledge of the Treatment of Infantile Paralysis*. For the general meeting on Tuesday, January 18, Dr. Mary H. Layman will honor the Auxiliary with a discussion on the *Effect of Motion Pictures on Children*.

Plans are being formed for an Auxiliary dinner in February for members and their husbands. Mrs. Thomas Gibson and Mrs. George H. Becker will be chairmen of arrangements.

MRS. HARRY R. OLIVER,
Chairman of Publicity.

Basle Nomenclature in Anatomy.—The BNA (Basle nomina anatomica) is the product of the Commission on Nomenclature appointed by the Anatomical Society in 1889. Its report (the BNA) was accepted in 1895 at a meeting in Basle, Switzerland.

This society was international; in 1895 it had 145 German members and 129 members from other nations. The chairman of the commission was Prof. W. Krause of Berlin; the members included Prof. G. D. Thane of London, and representatives of several other countries were invited to join it. They were among the ablest anatomists of that time.

The need for it appeared in the multiplication of terms. More than 30,000 were in the literature for 4,500 structures. Wilder, Gould and Gage in America, Henle in Germany, and the anatomic societies of Germany, Britain and America had urged the necessity of simplification.

The commission served without pay. The cost of correspondence and mimeographing was about $3,000; it was defrayed by scientific academies of Germany and Austria Hungary and by the Anatomical Society.

The plan included only names of descriptive gross human anatomic structures. Personal names were omitted except as some few had become universally adopted and firmly established as to make their omission impossible—these were added in brackets. The governing principles were as follows:

1. Each part shall have only one name.
2. It shall be in Latin, philologically correct. (Most names were in Latin form anyway and Latin is the only international language.)
3. It shall be short and simple.
4. It need not be descriptive nor speculative.
5. Related terms shall be similar.
6. Adjectives shall, in general, be arranged as opposites, as major-minor; superficialis-profundus.

More minute terms used in the medical specialties were omitted.

The work was admirably done. More than five-sixths of names previously used locally were abandoned—they were not necessary. The arrangement of terms indicated the normal structure—branches of vessels, nerves and others. The use of these names in the atlases of Spalteholz, Toldt, and Sobotta and in the textbooks of all countries led to its adoption almost universally, to the great advantage of medical sciences and of medical students.

The International Association of Anatomists, established later, has continued the revision. It has now a Commission on Nomenclature, including several American members; Professor Jackson of Minnesota is chairman of the American section. The commission has suggested a few changes and is now considering others.

Types of Pneumococci in Sputum of Patients with Pneumonia.—Of the 192 strains from the sputum of patients with croupous or bronchial pneumonia out of 300 type-identified strains of pneumococci tabulated by Nissen, the predominating types were I, present in 35.9 per cent, VII in 10.4, III in 9.4, VI in 73, IV in 5.2, and VIII in 4.7 per cent. In rubiginous sputum from eighty-three patients, pneumococcus types I, VII, IV, and III were most frequent; type-specific agglutinins in the blood were established with rising and falling titer in the cases in which types I, IV, and VII appeared in the sputum.—*Ugeskrift for Laeger.*

MISCELLANY

Under this department are ordinarily grouped: News Items; Letters; Special Articles; Twenty-five Years Ago column; California Board of Medical Examiners; and other columns as occasion may warrant. Items for the News column must be furnished by the fifteenth of the preceding month. For Book Reviews, see index on the front cover, under Miscellany.

NEWS

Coming Meetings

American Medical Association, San Francisco, June 13–17, 1938. Olin West, M.D., 535 North Dearborn Street, Chicago, Secretary.

California Medical Association, Hotel Huntington, Pasadena, May 9–12, 1938. F. C. Warnshuis, M.D., 450 Sutter Street, San Francisco, Secretary.

* * *

American Academy of Orthopedic Surgeons, Los Angeles, January 16–20, 1938. Carl E. Badgley, M.D., 1313 East Ann Street, Ann Arbor, Michigan, Secretary.

Pacific Coast Surgical Association, Los Angeles, February 22–25, 1938. H. Glenn Bell, M.D., University of California Hospital, San Francisco, Secretary.

Medical Broadcasts*

Los Angeles County Medical Association.

The radio broadcast program for the Los Angeles County Medical Association for the month of January is as follows:

Saturday, January 1—Holiday (New Year's).

Thursday, January 6—KECA, 11:00 a. m., The Road to Health.

Saturday, January 8—KFI, 9:15 a. m., The Road to Health; KFAC, 11:00 a. m., Your Doctor and You.

Thursday, January 13—KECA, 11:00 a. m., The Road to Health.

Saturday, January 15—KFI, 9:15 a. m., The Road to Health; KFAC, 11:00 a. m., Your Doctor and You.

Thursday, January 20—KECA, 11:00 a. m., The Road to Health.

Saturday, January 22—KFI, 9:15 a. m., The Road to Health; KFAC, 11:00 a. m., Your Doctor and You.

Thursday, January 27—KECA, 11:00 a. m., The Road to Health.

Saturday, January 29—KFI, 9:15 a. m., The Road to Health; KFAC, 11:00 a. m., Your Doctor and You.

Decoration Bestowed upon Dr. J. C. Geiger.—The following letter refers to an honor recently bestowed upon Dr. J. C. Geiger, Director of Public Health, City and County of San Francisco:

(COPY)

CONSULADO DE CHILI

San Francisco, California,
December 6, 1937.

My dear Doctor Geiger:

It gives me great honor to inform you that I have just received a letter from the President of the Chilean Delegation to the Orient, the Honorable Senator Maximiano Errazuriz, in which he asked me to advise you that the Government of Chili has granted to you the decoration, "Cruz de Caballero de la Orden del Merito," for your good friendship and assistance to my country and for your excellent work in and outstanding contributions to public health.

The diploma and insignia will be sent in the near future.

As representative of Chili, I wish to extend to you my sincere congratulations for this public recognition by my Government.

Very sincerely,

(Signed) MARIO ILANES,
Consul of Chili.

* County societies giving medical broadcasts are requested to send information as soon as arranged (stating station, day, date and hour, and subject) to CALIFORNIA AND WESTERN MEDICINE, 450 Sutter Street, San Francisco, for inclusion in this column.

Trichinosis.—An outbreak, involving twenty cases of trichinosis, was investigated during October by the State Board of Public Health. They were found on the route of a peddler who sells delicatessen meats. The source of infection was in improperly processed smoked ham, which came from a small establishment.

The American Board of Internal Medicine: Written Examination.—The American Board of Internal Medicine will hold its next written examination on Monday, February 14, 1938, in various centers of the United States and Canada.

The examination will consist of two sessions of three hours each, with the morning session held at nine o'clock and the afternoon session held at two o'clock.

The candidates who are successful in this written examination will be eligible to take the practical examination which will be held in San Francisco the Friday and Saturday prior to the opening of the annual session of the American Medical Association in June, 1938.

The final date for filing applications for this written examination is January 15, 1938, and all applications should be in the office of the chairman before that date.

For further particulars and application blanks, please address Walter L. Bierring, M.D., Chairman, American Board of Internal Medicine, Suite 1210, 406 Sixth Avenue, Des Moines, Iowa.

Los Angeles Heart Association.—The sixth annual symposium on heart disease was held in Los Angeles on December 16 and 17, 1937. The program is given below:

Thursday, December 16

8 p. m.

(Joint Meeting with Los Angeles Clinical and Pathological Society)

Social Aspects of Heart Disease—John C. Ruddock, M.D.

The Surgical Treatment of Hypertension—Arthur L. Bloomfield, M.D., and David A. Rytand, M.D.

(By Invitation)

Friday, December 17

Morning Session, 9:45 a. m.

Diuretics—William Paul Thompson, M.D.

The Heart in Relation to Asthma and Emphysema—J. J. Singer, M.D.

The Management of Children with Rheumatic Heart Disease—Louis E. Martin, M.D.

The Heart in Hyperthyroidism—Phillip Corr, M.D.

Digitalis—Norman F. Crane, M.D.

Influence of Improper Diets upon the Heart—William Boeck, M.D.

Friday, December 17

Afternoon Session, 2 p. m.

Cardiac Care after Decompensation—R. Manning Clarke, M.D.

Heart Disease in Relation to Anesthesia and Surgery—J. F. Anderson, M.D.

Roentgenographic Methods in Cardiovascular Diagnosis—Wilbur Bailey, M.D.

Pericarditis—A. M. Roberts, M.D.

The Cardiac Neuroses—Verne Mason, M.D.

Errors in Cardiac Diagnosis—Louis E. Viko, M.D.

(By Invitation)

Evening Session, 8 p. m.

President's Address—William H. Leake, M.D.

The Use of Electrical Amplification in the Interpretation and Analysis of Heart and Lung Sounds—Louis E. Viko, M.D.

(By Invitation)

Collections of electrocardiograms, roentgenograms, and pathological specimens will be exhibited during the Friday sessions. E. Richmond Ware, M.D., William H. Leake, M.D., Ernest M. Hall, M.D., John W. Budd, M.D.

Into the Medical Corps of the Navy: Examination for Entrance.—An examination of candidates for appointment as lieutenant (junior grade) in the Medical Corps of the Navy will be held at all naval hospitals in the United States and at the Naval Medical School, Washington, D. C., beginning May 16, 1938.

Candidates for admission must be between the ages of twenty-one and thirty-two years at time of appointment, graduates of Class "A" medical schools, and have completed an internship of one year in a hospital accredited for interns by the American Medical Association and the American College of Surgeons.

Those who are interested should write the Surgeon-General, United States Navy, Bureau of Medicine and Surgery, Navy Department, Washington, D. C., for further information in regard to the examination and the procedure to follow for them to appear before one of the examining boards.

American Public Health Association.—The officers of the American Public Health Association (address, 50 West Fiftieth Street, New York, N. Y.), announce that the sixty-seventh annual meeting will be held in Kansas City, Missouri, October 25-28, 1938.

Dr. Edwin Henry Schorer, Director of the Kansas City Health Department, has been appointed chairman of the local committee. He will be assisted by a large group of city and state officials and community leaders.

A long list of affiliated organizations meet habitually with the American Public Health Association. They include: The American Association of School Physicians; the Association of Women in Public Health; the Conference of State Laboratory Directors; the Conference of State Sanitary Engineers; the American Association of State Registration Executives; Delta Omega; and the International Society of Medical Health Officers.

The attendance at the sixty-seventh annual meeting will exceed three thousand professional public health workers from every state in the Union, Canada, Cuba, and Mexico.

Grant Gives Big Impetus to Cancer Work at the University of California.—The means for greatly increasing the production of radio-active substances for the treatment of cancer and other diseases, and greatly decreasing the cost of such substances, has been placed in the hands of the University of California through a grant of $30,000 by the National Advisory Cancer Council of Washington, D. C. The grant has been made directly to Dr. E. O. Lawrence, professor of physics and head of the University of California's Radiation Laboratory, and comes on the eve of the removal of the laboratory to new and larger quarters on the campus.

The grant, according to Doctor Lawrence, will be applied to increasing the output of the new cyclotron, which is to be installed in the new laboratory early next year. The present cyclotron has already produced some two hundred radio-active substances, such as radio-sodium, radio-phosphorus, and radio-iron, and these will be applied to medical problems in the new laboratory. The new cyclotron is accordingly being called the "medical cyclotron."

The Radiation Laboratory already has produced radio-active substances equal in temporary radio-activity to one gram of radium. These amounts have been found adequate for hospital experimental use and at the present time can be produced at a cost comparable with that of radium. As the cyclotron is in the very earliest stages of technical development, Doctor Lawrence expresses the belief that its efficiency can be greatly improved, and it can be made to produce the equivalent of ten grams or more of radium at a consequent reduction in cost of manufacture of the radio-active substances. The fund from the National Advisory Cancer Council was given Doctor Lawrence in order that the radio-active substances may be made more cheaply and more abundantly and that they may cover the greatest possible ground in biological experimentation and application. Perhaps the most important feature of the newly created substances is that they are nontoxic, and may be taken into the digestive tract or administered intravenously without harmful consequences. They also permit a close observation of their action on the blood and the body otherwise through the "tagging" of atomic content through radio-active properties.

Los Angeles Surgical Society.—The annual meeting of the Los Angeles Surgical Society was held on Friday and Saturday, December 10 and 11, 1937, with headquarters in the Los Angeles County Medical Association Building. The program of the meeting follows:

Friday, December 10

9 a. m.

Dry Surgical Clinic, Los Angeles County Hospital
John F. Erdmann, M.D., New York
Guest Speaker

Bone Malignancies—Paul E. McMaster, M.D.

Gastroscopic (Demonstration)—John F. Renshaw, M.D. (By invitation.)

12:30 p. m.

Luncheon—County Medical Building
1925 Wilshire Boulevard

2 p. m.

Some Important Points in Aseptic Intestinal Resection—Foster Collins, M.D.

Operative Treatment of Dislocated Peroneal Tendons (slides)—Ellis Jones, M.D.

Immediate Repair of Divided Nerves and Tendons of the Hand (motion picture)—John E. Kirkpatrick, M.D.

Hour-Glass Tumor of the Spinal Cord—Mark Glaser, M.D.

Volvulus of the Cecum—E. Eric Larson, M.D.

Cancer of the Rectum with Complications—William Daniel, M.D.

Some Cases of Bone Tumor— A. E. Gallant, M.D.

Recess Ten Minutes

Hemorrhagic Cysts of the Kidney—A. J. Scholl, M.D.

An Evaluation of Common Anesthetic Methods—Arthur E. Guedel, M.D. (By invitation.)

Treatment of Hemorrhoids by the Injection Method—William Kiger, M.D.

Chronic Subdural Hematoma as a Problem in the Differential Diagnosis of Intracranial Lesions—Leo J. Adelstein, M.D.

Acute Perforation of Gastrojejunal Ulcer—Harold Thompson, M.D.

Regional Ileitis—Joseph Jellen, M.D. (By invitation.)

Retrotracheal Intrathoracic Toxic Adenoma of the Thyroid—Verne C. Hunt, M.D.

Annual Dinner, 7 p. m.

Saturday, December 11

9 a. m.

Dry Surgical Clinic, Los Angeles County Hospital
John F. Erdmann, M.D.

Malignancies of the Lower Urinary Tract—H. C. Bumpus, M.D.

Demonstration of Peritoneoscope—John Ruddock, M.D. (By invitation.)

12:30 p. m.

Luncheon—County Medical Building
1925 Wilshire Boulevard

2 p. m.

A Critical Analysis of One Thousand Cases of Appendicitis—E. C. Moore, M.D.

Recent Advance in the Treatment of Head Injuries—Carl Rand, M.D.

Solitary Paratyphoid Lesion of the Large Bowel—Wayland Morrison, M.D.

Injection Treatment of Hernia—William Weber, M.D.

Fatalities in Hernia Injection—Clarence J. Berne, M.D.

A Ruptured Appendix That Spontaneously Drained Through the Internal Abdominal Ring and Down the Canal of Nuck—Burns Chaffee, M.D.

Treatment of Urinary Extravasation (with motion picture)—Carl Rusche, M.D.

Recess Ten Minutes

Carcino-Osteogenic Sarcoma of the Chest Wall with Five-Year Follow-Up (with slides)—Frank Breslin, M.D.

Treatment of Occlusive Vascular Diseases — Vernon Thompson, M.D. (By invitation.)

Surgery of the Elderly Patient—J. N. Nichols, M.D.

Postoperative Complications, 1234 Cases—L. A. Alesen, M.D.

The Problem of Testicular Malignancy—Franklin Farman, M.D.

The Administration of Sulfanilamid—Albert Bower, M.D. (By invitation).

Reconstruction of a Mutilated Face Resulting from Automobile Accident (motion picture)—Arthur E. Smith, M.D.

American Board of Obstetrics and Gynecology: Examinations.—The next examination (written and review of case histories) for Group B candidates who have filed applications will be held in various cities of the United States and Canada on Saturday, February 5, 1938.

The general oral, clinical and pathological examinations for all candidates (Groups A and B) will be conducted by the entire Board, meeting in San Francisco, on June 13 and 14, 1938, immediately prior to the meeting of the American Medical Association.

Applications for admission to the June, 1938 Group A examinations must be on an official application form and filed in the secretary's office before April 1, 1938.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

Poor Health and Worry Insignificant at State University.—Poor health, worry about self or family, failure to make friends, emotional upset and other factors that are usually held responsible for improper adjustment of the University student to his surroundings and his studies, appear to be comparatively insignificant at the University of California. Intensive studies of the adjustment problem, made by Dr. Merton E. Hill, director of admissions, on one thousand transfers from junior colleges, show that the problem is far less concerned with the personal make-up of the student, as it is with outside influences, such as the time taken for self-support, and insufficient funds.

But 1.1 per cent of the group examined found their studies and activities hindered by poor health. None could be found who lacked medical care. Worry about home or family interfered with the school work of but 1.3 per cent. Failure to make friends concerned only 0.6 per cent, while the lack of student activities concerned only 0.4 per cent.

Emotional upset, which is supposed to cause many young people to quit school, claimed but 2.4 per cent of the group examined. Slow reading habits hindered 4.0 per cent, while living arrangements affected the work of 3.6 per cent.

The college course which causes the most difficulty appears to be economics. Chemistry comes next, but such supposedly "tough" subjects as astronomy, bacteriology, and biochemistry proved a stumbling-block for less than ten students for each of these subjects, out of the 905 who were questioned concerning them. The proportions are made more even, however, by reason of the fact that there are a great many more students taking economics than the other subjects.

Annual Expenditures of California State Board of Public Health.—On page 174 of the "Formal Report on Factual Data" of the California Medical Economic Survey is printed a table (Appendix G-13) that does not indicate how funds are allocated. Each county receives from the State $3 per week per patient to aid counties in the care of tuberculous citizens, as given in the first column of the table below. The administration expense of the State Board of Health, as expended through funds allocated by the legislature, is given in the fourth column (Total Administrative Expense).

	Total Tuberculosis Subsidies Paid	Total Administrative Expense[1]	Total Administrative Expense[2]
1920-1921	$106,721.13	$244,158.11	$255,863.72
1921-1922	150,456.92	290,372.31	305,099.12
1922-1923	156,612.36	303,764.35	318,179.98
1923-1924	176,755.71	184,697.10	193,021.46
1924-1925	214,429.23	216,415.41	224,871.98
1925-1926	235,117.97	225,556.64	276,540.22
1926-1927	257,312.76	262,528.37	334,154.65
1927-1928	287,697.27	260,338.93	344,826.07
1928-1929	237,119.09	288,930.92	384,753.26
1929-1930	378,876.73	292,951.82	404,582.96
1930-1931	440,255.79	326,417.01	458,051.69
1931-1932	482,259.59	304,987.45	402,908.07
1932-1933	519,726.50	284,783.71	372,138.50
1933-1934	550,785.68	201,847.65	304,318.44
1934-1935	562,116.51	208,547.56	325,671.61
1935-1936	589,151.85	226,257.36	388,697.83
1936-1937	304,573.32	255,951.11	500,310.28

[1] Exclusive of subsidy and exclusive of self-supporting activities and of those without legislative appropriation.

[2] Exclusive of the subsidy and special funds, but inclusive of cannery inspection and nurses' registration.

Dental Conferences.—The dental staff of the Bureau of Child Hygiene of the California State Board of Public Health is now composed of three dentists and a dental hygienist. They have worked in eleven counties, holding forty-one conferences, have instructed 1,868 children on the care of the teeth, and have examined the teeth of 357 children. In addition, 565 dental operations have been performed on seventy-one children. These activities during the month of October were carried on in Trinity, Modoc, Lassen, Alpine, and Mono counties. During the month, dental unit Number One, a fully equipped trailer, was exhibited before the Twelfth District Dental Society at Alturas.

Epidemiology.—In the new handbook of public health bacteriology issued under the auspices of the San Francisco Department of Public Health, Dr. J. C. Geiger, Director of that department, contributes an introductory chapter on epidemiology which is of interest. He states:

"Two modern weapons of public health work are bacteriology and epidemiology. Many of our older and sometimes successful health officials regard them as synonymous. As a matter of fact, lemology or lemography, meaning the sum of human knowledge as to pestilence, was known long before the science of bacteriology came into existence. The term "epidemiology" and its corresponding branch of the science of medicine, public health, are comparatively more actively used today and oftentimes the application to suitable problems is quite misunderstood, accordingly. Where disease affects the individual, the problem becomes that of the physician. Should this disease be of a communicable nature, like influenza, the locality, the city, the state, the nation, or the world may be involved.

On the other hand, diseases that are not communicable, such as those of the heart, but which may have some definite and perhaps controllable feature that can be applied to the population as a whole, can well come within the scope of epidemiological study. Likewise, the effect of disease on groups selected by age, sex, environment, climatic changes, occupation, even emotional and religious factors, may play their part. Therefore, epidemiology is a science with many ramifications, giving graphic or word pictures of the occurrence, incidence, distribution, the infectivity, the virulence of the causative microbic or viric factor, and the seasonal or calendar periodicity, both present and past, of communicable diseases."

A Human Death from Rabies.—A veterinarian residing in Los Angeles County was called July 19, 1937, to treat a small dog for suspected arsenic poisoning. While administering an antidote to the dog, he was bitten on both thumbs. The dog's teeth sank into the nail on one thumb and it was necessary to pry the dog's jaws apart in order to release the thumb. The animal died the following day and the head was taken to a laboratory, where an examination for rabies proved positive. The Pasteur treatment was administered within twenty-four hours to the veterinarian, who had been bitten by the animal. Iodin or some other antiseptic had been used on both wounds, but there was a delay of twenty-four hours in the cauterization with fuming nitric acid, which is the only proper agent to use for the purpose.

The Pasteur treatment of fourteen doses was completed uneventfully. About October 12 or 13, approximately ten weeks after completing the treatment, the patient suffered from headache, pain in hand and arm, was unable to sleep. On the following days he became progressively worse, ate with difficulty, unable to swallow, suffered from spasms upon attempting to drink, became irrational, requiring restraint, and died October 18, 1937.

The antirabies serum was manufactured by a reliable firm and had been kept under proper refrigeration. It would seem probable that the cauterization was late and did not destroy the virus under the thumb-nail. The Pasteur treatment is ineffective in a very small proportion of cases, and there is a possibility that this case fell in such a group. At all events, this unfortunate disaster emphasizes the fact that rabies is epidemic in California and that similar cases, tragic as they are, must be expected to occur until such time as the disease in animals, particularly dogs, may be brought under control.

University Has Important Data on Child Growth.—The data obtained by the Institute of Child Welfare of the University of California on different aspects of growth and development of children, cannot be duplicated elsewhere in the world. The utilization of this data is expected to develop a considerable reorganization in the techniques of teacher training in this State.

These conclusions have been reached by Dr. Daniel A. Prescott, member of the education faculty of Rutgers University, who is completing a year's study of both child and adolescent training in the University of California, under a special fellowship of the General Education Board, New York. The Board, which is actually a foundation maintained by Rockefeller funds, supports a number of the research activities of the institute.

Doctor Prescott listed twenty-three studies made by the Institute in the ten years of its existence, many of which concern aspects of growth and development in the same individual. The data range from biochemical tests and sociological findings to playtime behavior and samples of art produced by children of various ages. Not only will these studies figure in future teacher training, but they have many implications for the curricula of the secondary schools, Doctor Prescott said.

"These studies concern the problem of what the educators should know about children if they are to deal with them effectively," Doctor Prescott said. "The proper handling of the energy output, moods and emotions and the amount of work the pupil should do in the schoolroom and at home, are vitally concerned with these studies. The relation of physical growth to the child's social status is given attention, also.

"The task undertaken by the institute is a tremendous one, calling for a great deal of research."

Fourth Annual Postgraduate Assembly: Alumni Association, College of Medical Evangelists.—On Sunday, December 5, 1937, the Alumni Association of the College of Medical Evangelists presented the following program:

Morning Session

9:00 a. m.—Newer Developments in the Treatment of Arthritis, Dr. Robert Alan Hicks, Clinical Associate and Director of Laboratories, The Wyatt Clinic, Tucson.

9:30 a. m.—Treatment of Compound Fractures, Dr. Walter Ehalt, Chief Assistant Boehler Fracture Clinic of Vienna and Lecturer American Medical Association of Vienna.

10:00 a. m.—Contact Dermatitis, Dr. Laurence R. Taussig, Assistant Clinical Professor of Dermatology, University of California School of Medicine, San Francisco.

10:30 a.m.—Pneumoperitoneum in the Treatment of Pulmonary Tuberculosis, Dr. Edward W. Hayes, Associate Professor of Tuberculosis, College of Medical Evangelists School of Medicine, Los Angeles.

Recess

11:15 a. m.—Abdominal Surgery in Children, Dr. Loren R. Chandler, Associate Professor of Surgery and Dean of Stanford University School of Medicine, San Francisco.

11:45 a. m.—Certain Intraspinal Lesions as a Cause of Sciatica, Dr. Howard C. Naffziger, Professor of Surgery, University of California School of Medicine, San Francisco.

12:15 p. m.—The Present Status of Convalescent Serum Therapy, Dr. Clarence M. Hyland, Pathologist, Children's Hospital, Hollywood.

Afternoon Session

1:45 p. m.—Some Things the General Practitioner Should Know About the Eye, Dr. William A. Boyce, Professor of Ophthalmology, College of Medical Evangelists School of Medicine, Los Angeles.

2:30 p. m.—Treatment of Superficial Malignancies, Dr. Henry J. Ullmann, Director, Department of Cancer Research, Santa Barbara Cottage Hospital, Santa Barbara.

3:00 p. m.—Management of Vomiting in Children, Dr. Clifford D. Sweet, Chairman of Section on Pediatrics of American Medical Association.

3:30 p.m.—X-ray Treatment of Chronic Inflammatory Processes, Dr. Frederick Rodenbaugh, Director of the Radiological Departments, Franklin and Mary's Help Hospitals, San Francisco.

Recess

4:15 p. m.—Food Poisoning, Dr. Jacob Geiger, Department of Health, City and County of San Francisco.

4:45 p.m.—Medicine and Social Security, Dr. Morris Fishbein, Editor of *The Journal of the American Medical Association.*

5:15 p.m.—Painful Feet, Dr. Ernst Freund, Associate Professor of Orthopedics, College of Medical Evangelists School of Medicine, Los Angeles.

Evening Session

7:00 p. m.—Consideration of Rectal Diseases in General Practice, Dr. Malcolm R. Hill, Associate Professor of Proctology, College of Medical Evangelists School of Medicine, Los Angeles.

7:30 p. m.—The Treatment of Angina Pectoris, Dr. William Paul Thompson, Assistant Professor of Medicine, College of Medical Evangelists School of Medicine, Los Angeles.

8:00 p.m.—Urology in Children, Dr. A. Elmer Belt, Associate Professor of Urology, College of Medical Evangelists School of Medicine, Los Angeles.

8:30 p.m.—Acute Mechanical Obstruction of the Bowel, Dr. William B. Holden, Professor of Clinical Surgery, University of Oregon School of Medicine, Portland, Oregon.

Press Clippings.—Some news clippings dealing with matters related to public health activities or medical practice follow:

Doctors Quit Hospital as "Politics" Hit

Visiting Staff of San Luis Obispo Institution Demands a Complete Reorganization

San Luis Obispo, Dec. 16.—Resignation of physicians, surgeons, and dentists in San Luis Obispo County from service on the visiting staff of the County General Hospital was in the hands of the Board of Supervisors today.

The alternative to the wholesale resignation was, according to the hospital's visiting staff, a complete reorganization of hospital management, removing it from "political control" and placing it in the hands of the staff.

Doctors, surgeons, and dentists continued their hospital work today, but it was generally admitted that the formal filing of the resignations had brought to a head a long-continued dispute over hospital management.

One regular and one resident physician in San Luis Obispo and one regular physician in Paso Robles were unaffected by the resignation. The members of the visiting staff who resigned have been assisting the regular physicians.

Meeting Monday

The next meeting of the Supervisors is set for Monday.

Pointing out in the letter, signed by E. D. Anderson, secretary of the visiting staff, and by every member of the County Medical and Dental Associations, that "we stand ready to give our services to the County Hospital, provided that institution is operated for genuinely indigent patients and free from political influence," the doctors charge that "many patients have been admitted regardless of ability to pay."

This, they assert, places an unfair burden upon the taxpayers, who bear the cost of maintaining the hospital.—*Los Angeles Examiner,* December 17, 1937.

* * *

Doctors, Dentists Boycott Hospital, Accuse Politicians

San Luis Obispo, Dec. 17. (UP).—The County Hospital was under "boycott" today by the entire San Luis Obispo County medical and dental professions.

Doctors and dentists informed the County Supervisors they would no longer act on the visiting staff. They termed the hospital a "political football," claiming that county officials' friends, well able to pay for services, are being treated free. The two groups demanded a special welfare department to examine the financial condition of all hospital applicants.—*Los Angeles Examiner.*

* * *

Three New Regents

Los Angeles can be proud of the high type of citizen represented by the three choices for members of the Board of Regents of the University of California, as named by Governor Merriam. The filling of all three vacancies from this section was to equalize the Board geographically.

Eleanor Banning Macfarland, as a member of one of the Southland's oldest and most influential families, the Bannings, is intimately familiar with the fundamental problems of higher education. She, herself, took special courses at the University of California. As secretary of the English-Speaking Union and an authority on League of Nations work, she has a broad outlook on social problems of the day.

Stuart O'Melveny as head of the Title Insurance and Trust Company has proved his business acumen and keen discernment. He is the son of Henry W. O'Melveny, the pioneer attorney, and is himself a native of Santa Monica. His training is expected to be invaluable in helping to meet economic problems of the University.

Gratifying to this area, too, is the choice of young Fred Moyer Jordan, the first graduate of the University of California at Los Angeles to be named to the Board. Jordan is only twelve years out of college, but he has become widely popular in alumni circles. He is head of the U. C. L. A. Alumni Association at present.

The Governor is to be congratulated upon his choices. They are ably qualified to help guide the destinies of one of the world's greatest universities.—Editorial, *Los Angeles Times*, December 26, 1937.

* * *

Federal Control of Medicine Might Be Dangerous Plan

Federal control of medicine may have just been indorsed by 430 physicians in the East, but it is unlikely that it ever will be favored by a majority of the 164,000 other doctors who make up the profession in the United States.

Medical discovery and mechanical progress are the only two things that lift us above the level of the ancient races. In government and the arts we are no better than were the Greeks and Romans, perhaps not so good. And the willingness of modern people for war certainly is no advance from the age of stone or bronze.

Only in the conquest of disease have we exhibited any ascendant humanity or altruism. The discoveries of Harvey, Lister, Pasteur, and hundreds of other unsung heroes—and heroines—of medical research were highly individualistic.

Nationalization of medicine could only serve to dull personal effort and tangle a noble occupation in a maze of petty politics in which studious and sincere doctors would find themselves subordinated to less-meritorious handshakers. Nationalization, it might be said here, is merely the modern sugar-coated word for socialization—whether of medicine, railroads or electric power—and twenty-five years ago was branded Red Socialism.

With all doctors working for the Government, and dependent for advancement on political favor, the average citizen probably would have to call up the ward boss to get attention for a sick child in the middle of the night.

Soldiers are particularly aware of what happens under the regimentation of medicine. Army medical officers become unusually calloused to human ills.

It is only human nature. Every soldier on sick call is a suspected malingerer. Soldiers with pride will not report to the infirmary until they are ready to drop.

"Paint it with iodin and mark him 'Duty,' " is an Army sarcasm, purporting to be the usual order of the surgeon to the medical orderly, regardless of whether the applicant has appendicitis or a broken leg.

Attendants at governmental institutions, prisons especially, charge that an inmate must be at the point of death before he can get any treatment other than a dose of salts.

Those examples are possibly an indication of what civil medicine could become if a uniformed service reduced physicians—good and mediocre—to a common rank. Getting in line for attention at a medical clinic, even federal, or getting in line for anything—except a theater—is too European for the American taste.

Of course, federal control has more adherents than those 450 who recently endorsed it. Among this group were 125 from the remote country districts of the New England states. Doubtless, it is a struggle for a physician to maintain himself in thinly populated and impoverished areas. It might be possible for the Government to provide physicians so situated, East or West, with a subsidy, making up the difference between a fair income and what the doctor can collect from his patients, thus providing proper attention for the people of farms and villages.

People now living have seen more medical discoveries than were made in the preceding 2,300 years which spanned known medical history back to Hippocrates, the Greek father of medicine, whose oath to aid the sick without thought of self is still taken by every graduating surgeon today. Nearly all keep it.

Our present system, the trusted family physician with his recourse to specialists in emergency, could not be shackled without damaging the welfare of the people. Public medicine is necessary to a certain extent—but not to 100 per cent.

For instance, no Americans who can possibly pay, want machine-like and impersonal obstetrics for their families.

Perhaps, if many of us were as meticulous with the doctor's bill as we are with the rent and car payment, there wouldn't be any talk of federal control of medicine.—*Los Angeles News*, November 30, 1937.

* * *

Legislation Demanded

Washington.—W. G. Campbell, Food and Drug Administrator here, has demanded legislation empowering the Federal Government to prevent the marketing of dangerous drug mixtures, such as the sulfanilamide "elixir," before they have taken their deadly toll.

Supplementing his report on the activities of the Administration for the fiscal year ending June 30, 1937, he stated in an interview that the $200 fine for first offenses against the Food and Drug Act was "no deterrent at all" to a manufacturer.

Speaking specifically of the "elixir," responsible for scores of deaths throughout the United States because the sulfanilamide, hailed by doctors as a major medical advance, was mixed with diethylene glycol, a dangerous chemical, Mr. Campbell asserted that the manufacturer should have made it his business to learn that diethylene glycol was dangerous before he used it. He added that the Federal Government should have the power to see that drug manufacturers do not make "mistakes" like that one again.

* * *

Health Clinic Merger Urged

Consolidation of county and all municipal health organizations under one county-wide department of health was urged yesterday by Dr. Robert E. Plunkett of New York, nationally known health authority. He recently completed an exhaustive survey here in conjunction with the county's Bureau of Research.

Doctor Plunkett, who is general superintendent of tuberculosis hospitals for the State of New York, also recommended early construction of two 500-bed tuberculosis hospitals, with selection of patients to be under the direction of the County Health Commissioner.

Citing figures that tuberculosis mortality in the United States has fallen since 1900 from 202 persons per 100,000 population to fifty-five persons last year, Doctor Plunkett advised enlargement of clinic activities and unified nursing programs to maintain the advances.—*Los Angeles Examiner*, December 1, 1937.

* * *

Supervisors Urge New State Laws for Nonresident Relief

The Board of Supervisors today was on record as endorsing a drive seeking new state legislation which would extend relief to so-called "technical nonresidents" of Los Angeles County, following demands presented by the Workers' Alliance.

Three hundred members of the alliance jammed the board's assembly room yesterday to request an amendment of present state laws prohibiting relief for persons who have not been self-supporting in California for at least three years, one of them in the county where application for aid is made.

The board also ordered investigation of complaints against present administration policies of the county charities department after members of the workers' delegation voiced claims that hundreds of Los Angeles school children whose parents are on relief are suffering from malnutrition.—*Los Angeles Herald-Express*, December 7, 1937.

* * *

Rift Over Government Aid

New York, Dec. 1.—The split between the American Medical Association and the committee of 430 prominent physicians, of which Dr. Russell L. Cecil of New York Hospital is chairman, appeared appreciably widened yesterday, following a statement which Prof. John P. Peters of Yale University School of Medicine, handed out in reply to the attack the association's official journal made to the committee's four "principles" and nine "proposals" for changes in medical practice. Some of these would entail government support of certain aspects of materia medica.

The committee holds that "the health of the people is a direct concern of the government," whereas the American Medical Association view, voiced by its journal, is strongly against the proposals, holding that the government should not be permitted to influence, through money grants, medical practices or hospitalization.

Professor Peters, who is secretary of the committee, in a statement made public during the week-end, revealed for the first time that the program of his body had been presented to President Roosevelt by a small group of physicians and that the President had "listened graciously and sympathetically," but had made no commitments.

To Continue Campaign

Doctor Peters at the same time made it clear that his committee would continue its campaign to "liberalize" the American Medical Association and challenged the stand by the association's journal that no member of the association should support the committee's program. He denied that the association had rejected the committee's proposals, adding that should this happen, it would still be the "privilege" and, indeed, the "duty," of members of the committee to try by every reasonable means within their power to influence not only the governing body, but all the component societies and individual members to join them in a purpose they consider "good and just." . . .

* * *

Medic Alumni Will Banquet

More than 120 alumni of the medical school of the University of Southern California will gather tomorrow night

in the banquet room of the Los Angeles County Medical Association for their annual reunion.

Dr. H. B. Tebbetts, president of the alumni, will preside. Dr. Rufus B. von KleinSmid, president of the university, and Dr. Frank F. Barham, an alumnus, who is publisher of The Evening Herald and Express, will address the physicians.

Other Speakers

Dean Paul McKibbon of the Medical School, and Dr. George Kress, president of the Los Angeles County Medical Association, also will speak.

At the conclusion of the dinner, officers for the forthcoming year will be installed. Dr. Harold R. Witherbee, vice-president, will succeed Doctor Tebbetts. His place will be filled by Dr. Pierre Viole, present secretary-treasurer, who, in turn, will be succeeded by Dr. Anthony Lauber-sheimer.—*Los Angeles Examiner*, December 17, 1937.

* * *

Los Angeles Called No. 1 Quack Nest of United States

Up to State to Run Medical Charlatans Out of City, Dr. Morris Fishbein Declares

Los Angeles is America's No. 1 quack nest!

This was the declaration of Dr. Morris Fishbein, editor of the American Association Journal, yesterday when he addressed the fourth annual postgraduate assembly of the College of Medical Evangelists.

"It is high time state officials were driving the quacks out of business in Los Angeles," he said. "I have been in every city in the United States at least five times in the last two years, and I say without reservation that Los Angeles has more quacks than any other place in the country.

"This city is full of medical charlatans and numbo-jumbo practitioners of all kinds. It is up to the state of California to clean up the town!"

Ruin Many Lives

Doctor Fishbein declared medical quacks are ruining the lives of hundreds of persons every year.

"These fakirs with their lurid promises of cure-alls are bringing sorrow and tragedy to many of our citizens," he said. "I urge the men and women of the medical profession to join in the fight to end widespread quackery in Los Angeles."

Doctor Fishbein addressed one thousand physicians and surgeons in Paulson Hall of White Memorial Hospital.

Other speakers included Dr. Jacob Geiger of the San Francisco Department of Public Health, and Dr. Walter Ehalt, lecturer for the American Medical Association of Vienna.—*Los Angeles Examiner*, December 5, 1937.

* * *

Insulin Shock Saves Mind

Oklahoman's Mental Faculties Restored as Christmas Gift

Vinita (Okla.), Dec. 22. (AP).—A 29-year-old oil-field worker went home from the State Hospital today with a priceless Christmas gift—a clear, sound mind.

Doctors said he had been rescued from insanity by "shocks" of insulin.

Dr. Felix M. Adams, superintendent, explained that the patient, an inmate for five years, was the second dementia praecox cure out of an original group of eight started on the insulin treatment by the hospital last August.

Reaction Gratifies

"It is grand the way they react," he said. "They all improve physically at first.

"Two others, one a college graduate who majored in mathematics, the other a farm boy, could not answer questions coherently a few weeks ago. Now they organize their thoughts and express them lucidly. They are going home for a while. Though not quite normal, they may not have to come back.

"And this other young fellow who is going home for Christmas with his mother and sister, why, he's tickled to death, and as grateful. What a priceless Christmas gift for the family!"

Others to Get Care

A new group of twenty-five patients will be started on the insulin treatment soon. Even with the results so far, Doctor Adams believes a record for the insulin method has been set here. Previous experiments in Europe and the United States had been limited to dementia praecox cases of two years' duration.—*Los Angeles Times.*

* * *

California Clinics to Spread New Health Methods

San Francisco, Dec. 18.—To insure that the developments of medical science may be carried from one end of the state to the other as quickly as they issue from the clinics and laboratories of the central medical centers, the California Medical Association has launched a five-year plan of field demonstration and study clinics. Nine cities—Stockton, Fresno, Riverside, San Bernardino, San Diego, Santa Barbara, San Jose, Santa Rosa, and Sacramento—have been suggested for the first of the clinics, and other cities will be added as the plan develops.

The plan, which has been titled "A Five-Year Study Program for Graduates in Medicine," links the medical centers of the Universities of California, Stanford, and Southern California, and the College of Medical Evangelists in Los Angeles, in the effort to establish numerous other centers strategically, and thereby assure a simultaneous spread throughout the state of the very latest procedures and developments in the healing sciences. Under the plan physicians and surgeons in the remotest places, who have found it difficult to take advantage of the consultation facilities provided by the large centers, may now go to the nearest clinic center and take advantage of those facilities to the fullest degree.

The clinics will be conducted by faculty members from the four centers named. In addition, the committee in charge contemplates forming teams of clinicians who will conduct a series of conferences in key centers in northern California.

In its preliminary announcement the Association states that the plan has been devised to enable the practitioner in the field to remain abreast of scientific progress, and to apply to his practice the newer procedures without delay, no matter how far he may be from the originating source.

The field clinics are the outgrowth of a partial field demonstration plan tried out by the University of California Medical School two years ago.—*Los Angeles Herald-Express.*

* * *

Asserts Pacific Coast Smuggling of Dope Drops

Washington, Dec. 18. (AP). — Intensive war against smugglers, waged by the enforcement unit of the Customs Bureau, has virtually stopped importation of illegal narcotics on the Pacific Coast.

E. G. Shamhart, chief of the unit, said today no narcotics smuggled from the Orient had been seized on the west coast in months, while that which had been captured was found to have been smuggled through New York and shipped to coast peddlers.

Shamhart attributed the decrease of the smuggling on the Pacific to the expanded enforcement unit which circled the coasts and borders of the nation, with customs agents trained in the work of trapping smugglers. He said the ship strike on the West Coast and the war in the Far East had put the finishing touches to the criminals. . . .

LETTERS

Concerning American Red Cross: A letter of appreciation.

THE AMERICAN RED CROSS
NATIONAL HEADQUARTERS

Washington, D. C.,
December 1, 1937.

To the Editor:—Please allow me to express to you in behalf of our national officers our very sincere appreciation for the generous contribution of space which you gave to the American Red Cross in CALIFORNIA AND WESTERN MEDICINE. It is only through the splendid coöperation which you and others give to us each November that we are enabled to extend a universal invitation to all Americans everywhere to participate in Red Cross work through individual memberships.

Cordially yours,
(Signed) DOUGLAS GRIESEMER,
Director of Roll Call.

Concerning the California Heart Association.

CALIFORNIA HEART ASSOCIATION
FOR THE STUDY AND PREVENTION OF HEART DISEASE

San Francisco,
October 15, 1937.

To the Editor:—The California Heart Association is now pushing forward the program which has been carefully worked out by the leading medical authorities of the State. These activities will be of greatest importance and will have a direct effect upon every practicing physician in California.

This program correlates and enlarges the work which has been carried on for the last ten years by the Los Angeles Heart Association in Southern California and

the work of the San Francisco Heart Committee in the northern part of the State.

Dr. W. P. Shepard of San Francisco heads a committee of physicians, attorneys, and industrial leaders, who have addressed themselves to the problem of heart disease in industry. The answer to specific questions is being sought by four well-organized subcommittees.

Under the leadership of Dr. Wilton L. Halverson of Pasadena, detailed studies have been outlined to obtain all possible specific knowledge about rheumatic fever in California.

The Executive Committee of the Association has been working in conjunction with the California Medical Association's standing Committee on Postgraduate Activities for many months. Within a short time a five-year course of instruction in all branches of heart and circulatory diseases will be offered to all doctors of the State.

Continuing the work of past years, a two-day symposium on heart disease was held in San Francisco, November 17 and 18; and another in Los Angeles, December 2 and 3. Each year these meetings add notable contributions to our knowledge of heart and circulatory diseases.

The California Heart Association has made a promising beginning. Many very prominent laymen in the State have expressed their conviction that our objectives are worthy of support and they are demonstrating their support by subscribing to our organization. But to be successful we must have 100 per cent support of the medical profession.

Membership in the Association entitles one to receive the monthly publication, *Modern Concepts of Heart Disease*, valuable reports and data gathered by all committees, and to receive the benefits of all our proceedings. Dues are very nominal, being only $2 a year. Correspondence is invited.

45 Second Street.

Very sincerely yours,
JOHN C. RUDDOCK,

Concerning rabies in City and County of San Francisco.

(COPY)

San Francisco,
December 20, 1937.

Subject: Possibility of Rabies in San Francisco in Animals and in Humans.

To the Editor:—It will be of interest to note that the last case of human rabies reported in San Francisco occurred in 1913, following an intensive outbreak in dogs in 1912. This particular occurrence is of interest to the writer personally, since the outbreak of rabies in California in 1912 brought him originally to California in the same year to establish a Pasteur Institute at the University of California.

There were reported in San Francisco in 1912, two hundred and eighty-two animals suffering from rabies, mainly dogs. The last reported rabies in dogs in San Francisco occurred in 1929. Within the last two weeks two animals (dogs) suffering from rabies have been reported from Daly City, practically on the border line of the City and County of San Francisco.

It will be of further interest to note that since 1920 there have been reported in the State of California 13,128 animals with rabies and fifty-two deaths in human beings from the same disease. The greatest number ever reported in any single year has occurred in the past year, 1937, namely, 2,062 cases of rabies in animals with two cases in human beings. Of course, it is definitely understood that rabies in human beings or animals is 100 per cent fatal, there being no known cure or treatment when the disease becomes manifest.

It is because of the close proximity of recent cases in Daly City that the above facts have been ascertained and that definite warning is given accordingly. This warning is of particular significance to the Society for the Prevention of Cruelty to Animals inasmuch as they have control of stray animals, especially dogs and cats which are the reservoir of the disease. The area in the City and County of San Francisco nearest Daly City is our present danger spot, and we are requesting the Society for the Prevention of Cruelty to Animals to concentrate on the capture of stray dogs in this vicinity. If any dog is known to have been bitten by another animal suffering from rabies it is best to destroy it, inasmuch as the incubation period may extend from two weeks to six months and perhaps longer. Moreover, the present immunication of dogs that have been exposed to the disease has not always proved a practical procedure. The immediate treatment of dog bite is the immediate use of fuming nitric acid cauterization of the bitten area, and the report of the occurrence to the Department of Public Health.

Office of Director of Public Health,
City and County of San Francisco.

Sincerely,
J. C. GEIGER, M.D.,
Director.

Concerning California Postgraduate Supplement.

South Bend, Indiana,
December 6, 1937.

Dear Doctor Warnshuis:

Thank you very much for the supplement to CALIFORNIA AND WESTERN MEDICINE, giving the five-year study program for graduates in medicine.

I am tremendously interested in the subject of "Postgraduate Education." I believe that the maintenance of high standards of medical service is of the very greatest importance to the future of medicine as against various schemes for socialization.

Please convey my congratulations to Chairman Ruddock and his Committee for a very good piece of work.

Sincerely yours,
(Signed) R. L. SENSENICH. M.D.*

Concerning botulism outbreak in Tucumcari, New Mexico.

OFFICE OF
DIRECTOR OF PUBLIC HEALTH
CITY AND COUNTY OF
SAN FRANCISCO

November 19, 1937.

To the Editor:—Relative to the news report of an outbreak of botulism in New Mexico, I am sending you copy of a telegram sent this day to the Health Officer, Tenth District, Portales, New Mexico.

Sincerely,
J. C. GEIGER, M.D.,
Director.

* * *

(COPY)
WESTERN UNION

November 19, 1937.

Dr. L. A. Dewey
Health Officer, Tenth District
Portales, New Mexico

Re botulism outbreak Tucumcari [an] apparent favorable result. Similar outbreak [in] San Francisco [was] experienced after intravenous injection [of] one thousand cc. 10 per cent glucose solution, administered daily, according to indications. Dosage given for adults. Children according to weight.

J. C. GEIGER, M.D.,
Director, Public Health.

Concerning leaflets by the Nursing Information Bureau.

New York, November 1, 1937.

Dear Editor:

Physicians more frequently, probably, than any other group of individuals, are consulted by young people who want to be nurses. Parents, too, who are concerned for their children's welfare, turn to their doctors for answers to such important questions as, "Is there a future in nursing for my child?" "Will she make a good nurse?" "What is the best nursing school for her to attend?"

The Nursing Information Bureau of the American Nurses' Association now has available two vocational pam-

* Doctor Sensenich is a member of the Board of Trustees of the American Medical Association.

phlets which should prove useful tools to physicians and others who are asked for this type of advice. They are designed for high school and college students interested in nursing, and discuss the opportunities within the profession, the meaning of "training," how to choose a nursing school, and the general admission requirements of nursing schools. Copies may be had on application to the American Nurses' Association, 50 West Fiftieth Street, New York City.

Sincerely yours,

MARY M. ROBERTS,
Director, Nursing Information Bureau.

Concerning appreciation for a talk on "Social Medicine."

(COPY)

WESTWOOD VILLAGE KIWANIS CLUB
Westwood Village, Los Angeles,
December 18, 1937.

Mr. S. K. Cochems,
Executive Secretary, Los Angeles
County Medical Association,
Los Angeles, California.
Dear Mr. Cochems:

In behalf of the Westwood Village Kiwanis Club, I want to take this opportunity to express to you their appreciation of the splendid talk which you gave before our Club under date of December 17, 1937. The subject which you chose, namely, "Social Medicine," was a very timely one and one which should be well followed out in order to protect the profession which you represent.

Personally, I only feel sorry that more of our big business enterprises are not equipping themselves with speakers to combat this present-day element which has been devastating our business and professional people for the past several years. However, as stated by you, that advising the communities and organizing to get people interested in this so-called social insurance should be handled through many businesses and organizations to get results. I know for one organization, namely, the Westwood Village Kiwanis Club, you will find them wholly in accord with your message.

I personally want to thank you for giving your valuable time in appearing before our Club, and I want to extend to you a personal invitation to visit our Club and partake of our fellowship at any time you happen to be in Westwood Village. With best wishes for a Merry Christmas and a Prosperous New Year,

Very truly yours,

CARL G. CHOLCHER,
President.

Concerning the Advisory Board for Medical Specialties.

New York, N. Y., November 4, 1937.

To the Editor:—The Advisory Board for Medical Specialties adopted the following resolution at its meeting in Atlantic City on June 6, 1937:

***Resolved,* That the President appoint four members of the Advisory Board for Medical Specialties with power to add to their number and to form a Commission on Graduate Medical Education to study the problems of graduate and postgraduate medical training, such a Commission to be comprised of representatives of the medical profession, the hospitals, the universities, the medical schools, and the licensing bodies.**

In keeping with that action, may I report that a Commission on Graduate Medical Education has been created, the personnel of which is attached.

The Commission will undertake to mobilize current opinions as to how the problems in this field can best be solved and to formulate the educational principles involved in graduate and postgraduate medical training. It is hoped that standards of training can be drawn up which will be of help to the Council on Medical Education and Hospitals and other agencies concerned with the inspection and evaluation of the facilities needed. There would be no duplication of effort nor conflict with the Council and these other agencies. The results of the studies by the Commission should be of real assistance to the specialty boards, the medical profession, hospitals, medical schools, state boards of medical examiners, and other institutions and organizations concerned with this phase of American medicine.

630 W. 168th Street.

Sincerely yours,

WILLARD C. RAPPLEYE, M.D., *President.*

* * *

ADVISORY BOARD FOR MEDICAL SPECIALTIES

Organized in 1933-1934 for the purpose of coördinating graduate education and certification of medical specialists in the United States and Canada.

This Board reports to and functions in conjunction with the Council on Medical Education and Hospitals of the American Medical Association.

OFFICERS AND EXECUTIVE COMMITTEE

Willard C. Rappleye, M.D., President, New York, N. Y.
W. P. Wherry, M.D., Vice-President, Omaha, Nebraska
Paul Titus, M.D., Secretary-Treasurer, Pittsburgh, Pennsylvania.
R. C. Buerki, M.D., Madison, Wisconsin.
W. B. Lancaster, M.D., Boston, Massachusetts.

MEMBER ORGANIZATIONS AND REPRESENTATIVES

(Names marked with an asterisk (*) are the corresponding secretaries of the respective boards.)

The Association of American Medical Colleges
*Louis B. Wilson, M.D., Mayo Foundation, Rochester, Minnesota.
Willard C. Rappleye, M.D., 630 W. 168th Street, New York, N. Y.

The American Hospital Association
*R. C. Buerki, M.D., 1300 University Avenue, Madison, Wisconsin.
G. Harvey Agnew, M.D., Canadian Medical Association, 184 College Street, Toronto, Canada.

The Federation of State Medical Boards of the U. S. A.
G. M. Williamson, M.D., 2½ South Third Street, Grand Forks, North Dakota.
*Harold Rypins, M.D., State Education Building, Albany, New York.

The National Board of Medical Examiners
*J. Stewart Rodman, M.D., 225 South Fifteenth Street, Philadelphia, Pennsylvania.
Waller S. Leathers, M.D., Vanderbilt University School of Medicine, Nashville, Tennessee.

The American Board of Ophthalmology
Walter B. Lancaster, M.D., 520 Commonwealth Avenue, Boston, Massachusetts.
*John Green, M.D., 3720 Washington Boulevard, St. Louis, Missouri.

The American Board of Otolaryngology
H. P. Mosher, M.D., 828 Beacon Street, Boston, Massachusetts.
*W. P. Wherry, M.D., 1500 Medical Arts Building, Omaha, Nebraska.

The American Board of Obstetrics and Gynecology
Joseph L. Baer, M.D., 104 South Michigan Avenue, Chicago, Illinois.
*Paul Titus, M.D., 1015 Highland Building, Pittsburgh, Pennsylvania.

The American Board of Dermatology and Syphilology
Howard Fox, M.D., 140 East Fifty-fourth Street, New York, N. Y.
*C. Guy Lane, M.D., 416 Marlborough Street, Boston, Massachusetts.

The American Board of Pediatrics
Borden S. Veeder, M.D., 3720 Washington Boulevard, St. Louis, Missouri.
*C. Anderson Aldrich, M.D., 723 Elm Street, Winnetka, Illinois.

The American Board of Psychiatry and Neurology
Franklin G. Ebaugh, M.D., Colorado Psychopathic Hospital, Denver, Colorado.
*Walter Freeman, M.D., 1028 Connecticut Avenue, Washington, D. C.

The American Board of Radiology
A. C. Christie, M.D., 1835 Eye Street, N. W., Washington, D. C.
*B. R. Kirklin, M.D., Mayo Clinic, Rochester, Minnesota.

The American Board of Orthopedic Surgery
Willis C. Campbell, M.D., 869 Madison Avenue, Memphis, Tennessee.
*Fremont A. Chandler, M.D., 6 North Michigan Avenue, Chicago, Illinois.

The American Board of Urology
Herman L. Kretschmer, M.D., 122 South Michigan Boulevard, Chicago, Illinois.
*Gilbert J. Thomas, M.D., 1009 Nicollet Avenue, Minneapolis, Minnesota.

The American Board of Internal Medicine
*Walter L. Bierring, M.D., Suite 1210, 406 Sixth Avenue, Des Moines, Iowa.

MEDICAL JURISPRUDENCE†

By HARTLEY F. PEART, ESQ.
San Francisco

Responsibility of Physician for Acts of Nurse: Doctrine of Res Ipsa Loquitur in Cases of Treatment by Means of Infra-Red Rays

The District Court of Appeal for the Third Appellate District has just decided the case of *McCullough* vs. *Langer*, 91 Cal. App. Dec. 444, in which the facts were these: Plaintiff commenced action against a physician and a nurse employed by the physician for alleged improper use of an infra-red incandescent lamp which caused permanent injury to plaintiff's leg in the nature of a third-degree burn. A jury returned a verdict in favor of the nurse, but against the physician. Two physicians testified for the plaintiff that the third-degree burn was the result of submitting tender devitalized flesh of a bruised thigh to extreme heat from the infra-red light for too great a length of time. It further appeared from plaintiff's testimony that a compress was placed over plaintiff's bruised thigh and left undisturbed over the wound with the heat of the lamp applied thereto for more than four hours without any effort being made by the physician to ascertain the result of such treatment. Plaintiff introduced evidence to the effect that the lamp would generate 140 degrees of heat in one hour and that the maximum heat which should be applied to that wound, under the circumstances, was not to exceed 110 degrees Fahrenheit.

The defendant physician appealed from the judgment against him, and two of the reasons which he urged for reversal of the judgment were:

1. That the exoneration of the nurse from negligence exempted him from liability because the nurse actually administered the infra-red heat treatment, and

2. That the trial court erroneously applied the doctrine of *res ipsa loquitur*.

With respect to the first contention of the defendant physician the District Court of Appeal held that since the nurse was acting under the direction of the physician and not acting independently, the physician was liable not merely because he was the nurse's employer, but also because he was a joint participant in the act complained of by the plaintiff. The following portion of the Court's opinion indicates the tremendous legal responsibility placed upon physicians for the acts of nurses and other assistants:

> Under the circumstances of this case the nurse was presumed to attend the patient under the supervision and direction of her employer, Doctor Langer. As the *McInerney* case, *supra*, states, the employer "was therefore liable not merely under the rule of respondeat superior, *but rather as a joint participant in the acts complained of.*" (*Armstrong* vs. *Wallace*, 8 Cal. App. (2nd) 429, 439.) In the case last cited, this Court said:
>
> "The surgeon had the power and, therefore, the duty to direct the nurse to count the sponges as a part of his work in the opening and closing of plaintiff's abdomen and the putting in and taking out of sponges, and *it was his responsibility to see that such work was done.*"

In the present case it was the *duty* of the doctor in his treatment of the patient to see that the compress and lamp were used in such a manner as to prevent the application of excessive heat and a consequent burning of the flesh. The supervision of the doctor is shown by his personal visits to the room of the patient and by the inquiry of the nurse addressed to him an hour before the burn was discovered as to whether she should not then change the compress and lamp, to which he replied, "Leave them until after his evening meal." The appellant was, therefore, not relieved of liability because of the verdict favorable to his codefendant.

With respect to the defendant physician's second contention, namely, that the trial court erroneously instructed the jury that the doctrine of *res ipsa loquitur* applied to the case, the District Court of Appeal stated that *res ipsa loquitur* ("the thing speaks for itself") applies to cases involving the negligence of a physician in the use of x-ray pictures taken for the purpose of diagnosing an ailment and also in the manner of actually treating the disorder. The Court said that in the present case the plaintiff was burned in some way unknown to him and as a result of the treatment of his injury by the physician and the nurse in his employ. It occurred while he was under the influence of opiates, which prevented him from knowing just what caused the burn. The Court then held that, under such circumstances, the doctrine of *res ipsa loquitur* was applicable and that the burden was on the physician to show that the third-degree burns were not occasioned by his negligence.

Hence, the court held mere proof that he was burned while undergoing treatment through the use of an infra-red incandescent lamp was sufficient to sustain the plaintiff's case and to cast responsibility upon the physician. The physician then had the burden of convincing the jury that he was not at fault.

† Editor's Note.—This department of CALIFORNIA AND WESTERN MEDICINE, containing copy submitted by Hartley F. Peart, Esq., will contain excerpts from and syllabi of recent decisions and analyses of legal points and procedures of interest to the profession.

SPECIAL ARTICLES

DR. PHILIP MILLS JONES (1870–1916)*

Philip Mills Jones, M.D., a member of the Board of Trustees of the Association, secretary of the Medical Society of the State of California, and editor of the "California State Journal of Medicine" died in San Francisco, November 27, 1916, from pneumonia.

He was born in Brooklyn, January 17, 1870, and after attending the Polytechnic Institute of Brooklyn, from which he was graduated in 1886, he entered the academic course in New York University and then took his course in medicine at the Long Island College Hospital, Brooklyn, and was graduated in 1891. After practicing in Brooklyn until 1900, he moved to California and became associated with the University of California, in the Department of Archeology. He took a prominent part in the reorganization of the Medical Society of the State of California in 1902 and since that time had been secretary of that constituent state association and editor of its official organ. In order to serve his state association more effectively, and because he had found difficulty in securing lawyers who appreciated the medical phases of legal questions, in October, 1916, Doctor Jones passed the necessary examinations and was admitted to the bar to practice as an attorney and counselor at law in all the courts in the State of California.

He represented his state association in the House of Delegates of the American Medical Association continuously from the session of 1903 to the session of 1908. At this latter session he was elected a member of the Board of Trustees of the American Medical Association and served in that capacity up to the time of his death. He was a member of the National Committee of One Hundred on

* Editor's Note.—In connection with comment made in this issue, concerning the late Philip M. Jones, founder-editor of the official journal of the California Medical Association, and because it has taken months to locate a photograph of Doctor Jones, the obituary notice which appeared in the *Journal of the American Medical Association* of December 2, 1916, is here reprinted for the information of present-day members, and as a contribution to the historical files of the California Medical Association. For editorial comment, see page 1.

PHILIP MILLS JONES, M. D.
1870-1916

Public Health and a Fellow of the American Academy of Medicine.

Besides possessing the ability to write in a brilliant and convincing style, Doctor Jones was an effective and forceful public speaker and devoted much time and energy to the propaganda for public-health measures throughout California and the other Pacific states.

For eight years Dr. Philip Mills Jones was a member of the Board of Trustees, in which position he worked faithfully, and was fearless in his stand for what he believed to be right and just. He was secretary of the Medical Society of the State of California and editor of its journal for fifteen years, and it was in these offices that his most effective work was done. Through his efforts the California profession developed one of the best organizations of any state—one that is doing splendid work—professionally, socially, and scientifically. He made the "California State Journal of Medicine" a publication of influence not only within its own territory, but also in other parts of the country. As editor of this journal, Doctor Jones was especially fearless in his attacks on fraud and quackery, whether it concerned the proprietary medicine evils or quackery as it related to the medical profession.

BASIC SCIENCE ACT*

Draft of Proposed Law

An Act to establish a state board of examiners in the basic sciences underlying the practice of the healing art, to provide for its organization and powers, to provide that certification by that board be a prerequisite to eligibility for examination for license to practice the healing art, and to define the healing art.

Note.—In some states the constitutions require that the title of an act express the purposes and contents of the act. The title set forth above will, it is believed, conform to such a requirement.

Be it enacted.

Note.—The enacting clause should follow the form customary in the state.

SECTION 1. *Basic Science Certificate Required.*—No person shall be permitted to take an examination for a license to practice the healing art or any branch thereof, or be granted any such license, unless he has presented to the board or officer empowered to issue such a license as the applicant seeks, a certificate of ability in anatomy, physiology, chemistry, bacteriology, and pathology (hereinafter referred to as the basic sciences), issued by the state board of examiners in the basic sciences.

Note.—The sciences named are those that may be fairly said to have the same implication, whether the practitioner proposes to practice nonsectarian medicine or to follow the dogma of some cult. Whatever may be said of separate licensing boards for the nonsectarian practitioner and the cultists, there seems to be no valid argument against a uniform examination in the basic sciences, particularly if the examination is conducted, as is here proposed, by persons who are not active practitioners of the healing art.

SECTION 2. *Healing Art Defined.*—For the purposes of this Act, the healing are includes any system, treatment, operation, diagnosis, prescription, or practice for the ascertainment, cure, relief, palliation, adjustment, or correction of any human disease, ailment, deformity, injury, or unhealthy or abnormal physical or mental condition.

Note.—This definition brings within its scope nonsectarian medicine, osteopathy, chiropractic, naturopathic, sanipractic, and other modes of healing. It is inclusive enough to cover dentists, nurses, chiropodists, pharmacists, optometrists, and others, but Section 17 excepts them from the operation of the Act.

SECTION 3. *Board of Examiners in the Basic Sciences Authorized.*—The Governor, within thirty days after this Act takes effect, shall appoint a state board of examiners in the basic sciences (hereinafter referred to as the board), consisting of five members. The members of said board shall be appointed one for one year, one for two years, one for three years, one for four years, and one for five years, from the dates of their respective appointments. On the expiration of the term of any member, the Governor shall fill the vacancy by appointment for a term of five years. On the death, resignation, or removal of any member, the Governor shall fill the vacancy by appointment for the unexpired portion of the term. Every member shall serve until his successor is appointed and qualified. The members of the board shall be selected because of their knowledge of the basic sciences aforesaid, and each member shall be a professor, or an assistant or associate professor, or an instructor on the faculty of the ———— or some other institution of learning in the State of ———— of equal rank. Each member shall have resided in ———— not less than one year next preceding his appointment. No member of the board shall be actively engaged in the practice of the healing art or of any branch thereof.

Note.—This section aims at the creation of an examining board in which, by reason of the overlapping of the terms of members, there will be a continuity of policy and administration. The section proposes to limit the appointment of members of the basic science board to members of the faculties of approved universities and colleges, if possible. There should be inserted at the appropriate place the name or names of such school or schools.

SECTION 4. *Organization of Board.*—The board shall organize as soon as practicable after its appointment. It shall have authority to elect officers, to adopt a seal, and to make such rules as it deems expedient to carry this Act into effect. The board shall keep a record of its proceedings, which shall be *prima facie* evidence of all matters contained therein. Every member shall receive ———— dollars per diem and actual expenses, when actively engaged in the discharge of his duties. The compensation of the members and the other expenses of the board shall be paid out of the fees received from applicants, but this is not to be construed as preventing appropriations to cover deficits. The treasurer of the board shall give such bond, running in favor of the State, as the State Treasurer may determine. The office of the board shall be in the state capital, and quarters for that office shall be assigned in the capitol building or some other building occupied by the state government.

SECTION 5. *Fees Payable by Applicants.*—The fee for examination by the board shall be ———— dollars. The fee for reëxamination within any twelve-month period shall be ———— dollars, but the fee for reëxamination after the expiration of twelve months shall be the same as the original fee. The fee for the issue of a certificate by authority of reciprocity, on the basis of qualifications as determined by the proper agency of some other state, territory, or the District of Columbia, shall be ———— dollars. All fees shall be paid to the board by the applicant when he files his application. The board shall pay all money received as fees into the state treasury, to be placed in a special fund to the credit of the board. The State Treasurer shall pay out of such fund all expenses incurred by the board, on vouchers signed by the president and the secretary of the board.

SECTION 6. *Examinations.*—The board shall conduct examinations at such times and places as it deems best. Every applicant, except as hereinafter provided, shall be examined

* Prepared by the Bureau of Legal Medicine and Legislation, American Medical Association, Chicago. Reprinted in CALIFORNIA AND WESTERN MEDICINE for its suggestive value to members of the California Medical Association.

to determine his knowledge, ability, and skill in the basic sciences. The examinations shall be conducted in writing, but may be supplemented by oral examinations, and if practicable shall be supplemented by examinations in the laboratory, dissecting room, and dispensary, and at the bedside. If the applicant receives a credit of 75 per cent or more in each of the basic sciences, he shall be considered as having passed the examination. If the applicant receives less than 75 per cent in one subject and receives 75 per cent or more in each of the remaining subjects, he shall be allowed a reëxamination at the examination next ensuing, on application and the payment of the prescribed fee, and he shall be required to be reëxamined only in the subject in which he received a rating less than 75 per cent. If the applicant receives less than 75 per cent in more than one subject, he shall not be reëxamined unless he presents proof, satisfactory to the board, of additional study in the basic sciences sufficient to justify reëxamination.

SECTION 7. *Requirements for Certificate.*—No certificate shall be issued by the board unless the person applying for it submits evidence, satisfactory to the board, (1) that he is not less than twenty-one years old; (2) that he is a person of good moral character; (3) that before he began the study of the healing art he was graduated by a high school accredited by the [insert state accrediting agency] or a school of similar grade, or that he possesses educational qualifications equivalent to those required for graduation by such an accredited high school; and (4) that he has a comprehensive knowledge of the basic sciences as shown by his passing the examination given by the board, as by this Act required. This shall not be construed to prevent the issue of certificates under the provisions of Section 8 of this Act.

Note.—No evidence is required of the applicant of the extent and nature of his knowledge of the basic sciences. These are to be determined by the board of examiners in the basic sciences by examination. The professional examining board to which the applicant must subsequently apply for his examination for license to practice is to be at liberty, it is proposed by Section 18, to accept the findings of the state board of examiners in the basic sciences with respect to the proficiency of the applicant in those sciences, or to reëxamine the applicant in those sciences on its own account.

SECTION 8. *Reciprocity.*—The board may in its discretion waive the examination required by Section 7, when proof satisfactory to the board is submitted, showing (1) that the applicant has passed in another State an examination in the basic sciences either before a board of examiners in the basic sciences or before a state board authorized to issue licenses to practice the healing art; (2) that the requirements of that state are not less than those required by this Act as a condition precedent to the issue of a certificate; and (3) that the board of examiners in the basic sciences in that state grants like exemption from examination in the basic sciences to persons holding certificates from the state board of examiners in the basic sciences of ——— or holding licenses to practice the healing art according to the method or school that the applicant proposes to follow, issued after examination by the proper licensing board of ———.

SECTION 9. *Appeals.*—Any person aggrieved by any action of the board may appeal to the ——— court of the county in which the appellant has his residence. Such appeal shall be taken by serving on the secretary of the board a notice of appeal, stating the action from which the appeal is taken and, if the appeal is from an order of the board, stating such order or the part thereof from which the appeal is taken, and filing with the secretary of the board a bond in the sum of $500, conditioned for the payment of all costs of the appeal and all damages sustained by any person because of the appellant's failure to comply with the terms of the action or order of the board, if such action or order be held to be legal and valid. On the filing and approval of such bond, the action or order, or the part thereof appealed from, shall be stayed pending the final determination of the controversy. Immediately on the perfecting of such appeal the secretary of the board shall transmit to the clerk of the court of such county the notice of the appeal and the bond, and a certified copy of all proceedings of the board relating to the action or order from which the appeal is taken; and such cause shall thereupon stand for trial at the first regular term of the court thereafter.

SECTION 10. *Certificates and Licenses Void.*—Any basic science certificate and any license to practice the healing art or any branch thereof, issued contrary to this Act, is void. Any licensing board which has issued a license on the basis of a void basic science certificate shall revoke or cancel that license. The procedure for such revocation or cancellation shall be in accordance with the provisions of the Act under which such license was issued, authorizing the cancellation or revocation of licenses generally. The certificate issued to any person by the state board of examiners in the basic sciences shall be revoked automatically by the revocation of his license to practice the healing art or any branch thereof.

SECTION 11. *Practice Without Basic Science Certificate Forbidden.*—Any person who practices the healing art or any branch thereof without having obtained a valid certificate from the state board of examiners in the basic sciences, except as otherwise authorized by this Act, shall be fined not more than ——— dollars or imprisoned for not more than ———, or both, in the discretion of the court.

Note.—The exception referred to in this section is governed by Section 17 of this Act.

SECTION 12. *Fraudulent Certificates Forbidden.*—Any person who obtains or attempts to obtain a basic science certificate by dishonest or fraudulent means, or who forges, counterfeits, or fraudulently alters any such certificate, shall be fined not more than ——— dollars or imprisoned not more than ———, or both, in the discretion of the court.

SECTION 13. *Fraudulent Licenses Forbidden.*—Any person who obtains or attempts to obtain a license to practice the healing art or any branch thereof from any board or officer authorized to issue any such license, without presenting to said board or officer a valid certificate issued to the applicant by the state board of examiners in the basic sciences, as in this Act required, shall be fined not more than ——— dollars or imprisoned not more than ———, or both, in the discretion of the court.

SECTION 14. *Issue of Fraudulent Licenses Forbidden.*—Any person who knowingly issues or participates in the issue of a license to practice the healing art or any branch thereof (1) to any person who has not presented to the licensing board a valid certificate from the state board of examiners in the basic sciences or (2) to any person who has presented to such licensing board a certificate obtained from the state board of examiners in the basic sciences by dishonesty or fraud, or any forged or counterfeit certificate, shall be fined not more than ——— dollars or imprisoned not more than ———, or both, in the discretion of the court.

SECTION 15. *Fees Paid Unauthorized Practitioners Recoverable.*—A person who has paid money or anything of value to a person not authorized to practice the healing art or any branch thereof, as compensation for services rendered in the practice of the healing art or any branch thereof, when the payor did not know at the time of payment that the payee was neither the holder of a certificate issued by the state board of examiners in the basic sciences nor authorized to practice without such a certificate, may recover such money or the value of the thing paid, by an action at law instituted within two years from the date of payment.

SECTION 16. *Enforcement.*—The state board of examiners in the basic sciences and the several boards authorized to issue licenses to practice the healing art and branches thereof shall investigate every supposed violation of this Act coming within the scope of the authority of such boards respectively, and report to the proper ——— attorney all cases that in the judgment of the board warrant prosecution. Every police officer, sheriff, and peace officer shall investigate every supposed violation of this Act that comes to his notice or of which he has received complaint and apprehend and arrest all violators. It shall be the duty of the attorney-general and of the several ——— attorneys to prosecute violations of this Act.

SECTION 17. *Exceptions.*—This Act shall not be construed as applying to dentists, pharmacists, nurses, optometrists, and chiropodists, practicing within the limits of their respective callings; nor to persons licensed to practice the healing art or any branch thereof in ——— when this Act takes effect; nor to persons specifically permitted by law to practice without licenses, who practice each within the limits of the privilege thus granted to him.

SECTION 18. *Saving Clause.*—Nothing in this Act shall be construed as repealing any statutory provision in force at the time of its passage with reference to the requirements governing the issue of licenses to practice the healing art or any branch thereof or as in any way lessening such requirements. But any board authorized to issue licenses to practice the healing art or any branch thereof may in its discretion either accept certificates issued by the ———— board of examiners in the basic sciences in lieu of examining the certificants in such sciences or it may examine such certificants in such sciences. The unconstitutionality of any part of this Act shall not be construed as invalidating any other separable part of it.

SECTION 19. *Short Title.*—This Act may be cited as Basic Science Act, 19——.

SECTION 20. *Repeal.*—All Acts and parts of Acts contrary to the provisions of this Act or inconsistent therewith are hereby repealed.

DOUGLASS W. MONTGOMERY*

Doctor Kelly has very graciously accorded me the privilege of saying a few words concerning our friend and colleague who is with us here tonight.

Too often we turn to the pages of our *Bulletin* and read an epitaph of a colleague no longer with us. Happily, tonight, while he *is* with us, we pause a few moments in our busy lives to pay tribute to Douglass Montgomery.

He has not only reached that enviable milestone in medicine, of a half-century of practice, but has accomplished still more; he now approaches his fifty-second year of continuous practice in San Francisco, and has been a generous member of the San Francisco County Medical Society most of those years. The archives of the American Medical Association reveal that only one physician in many thousands ever remains in active practice fifty years.

To get Doctor Montgomery to talk about himself is most difficult, as even there one encounters that Scotch trait of a bit of hesitancy in giving something away, including facts about himself. But having observed him occasionally for twenty years, I've garnered a few facts of interest to us. Canadian born, in 1859, of Scotch and Welsh parents, he was graduated from Upper Canada College, then attended Toronto Medical School for three years, going to Columbia for his final year, where he was graduated in 1882. After some time as chief of staff with the famous Halstead and Bull in New York, he went to Europe. There followed a productive three years in Italy, Heidelberg, Wurzberg, Vienna, Switzerland, London, and finally Edinburgh.

Then strangely enough a war brought him to San Francisco—a war between two railroads. One May day in 1886, he was strolling along the streets of St. Paul, Minnesota. The only two railroads to the West were having a rate war—even then. Douglass saw a sign which read: "$17.00 to Sacramento, California." He blinked his eyes and looked again; naturally, to a Scotchman that was like waving a red flag at a bull. His hand being in his pocket at the time, all he had to do was draw out the money and he was aboard. Luckily, it was spring, and as the train rolled over the blooming desert, Douglass congratulated himself upon getting to God's country for $17 and he stayed. Thus since May, 1886, San Francisco has had his valued services, first as the initial professor of pathology in the Toland Medical College for about five years; since then as one of the deans of dermatology of the West.

Doctor Montgomery is certainly the antithesis of Osler's famous remark about "the uselessness of men above sixty years of age . . . in professional life. . . ." He is proof that nobody grows old by merely living a number of years. People only grow old by deserting their ideals, and his are still with him.

As he approaches his seventy-ninth year of life, he walks daily from Fillmore and Vallejo streets to his office down town. He is in his office at ten in the morning and leaves late in the afternoon. His step is brisk, his carriage erect, and his energy remarkable.

For many years I've watched him in what would be our spare moments. On the automobile ferry, on a country hillside, in his office between patients, and in his home, I've seen him slyly withdraw a small volume in Greek, where an hour of counsel with one of the old masters would be had. And when one turns to literature for observations upon old age, one finds that it is the trend of the times to eulogize youth, and one quickly turns back to these very philosophers the doctor has never deserted. May I remind him of Cicero's words: "The fruit of old age is the memory of abundant blessings previously acquired." And again he wrote: "It is in the old men that reason and judgment are found, and had it not been for old men, no state would have existed at all."

Our own Oliver Wendell Holmes remarked that "to be seventy years young is sometimes far more cheerful and hopeful than to be forty years old."

I'm going to plagiarize from another author because I feel it is applicable to our guest tonight. In 1902, Sir William Osler wrote a tribute to the famous Alfred Stille; from that address I pluck the following: "Take the list of fellows of our Society, look over the names and dates of graduation of the practitioners of this city, and the men above seventy years of age form, indeed, a small remnant. All the more reason that we should cherish and reverence them. I only knew . . . after his seventieth birthday . . . the keenness of his mind on all questions relating to medicine. He had none of those unpleasant senile vagaries, the chief characteristic of which is an intense passion for opposition for everything that is new. He had that delightful equanimity and serenity of mind which is one of the most blessed accomplishments of old age. He had none of the irritating features of the old doctor who, having crawled out of the stream about his fortieth year, sits on the bank, croaking of misfortunes to come, and with less truth than tongue, lamenting the days that have gone and the men of the past."

I know of no one who has more thoroughly enjoyed the advance of the world than Douglass Montgomery. Last August 3, on his seventy-eighth birthday, he was merrily ensconced in a single motor plane with a Chinese pilot, flying up the Yangtze River of China, with his loyal wife and constant companion. The two of them made the round trip to China on the *Clipper* and, besides, went inland on rather doubtful planes.

His willingness to change to the new is best evidenced by what he told me last week. After being a Republican for seventy-eight years, and as well believing in a balanced diet and plenty of sleep, he discovered that Vice-President Garner goes to bed right after supper. Just a slight push and he'll be a Democrat. And as a modern story teller, he's a match for Tom Kelly, Junius Harris, or Morris Fishbein, any day in the week.

Doctor Montgomery, we're going to ask you to give us the secret of this fruitful life. Is it merely balanced diet and plenty of sleep; is it the hours of philosophizing you've had with ancient Greece and Rome; or is it the fact, being a dermatologist, you have taken advantage of the scientific fact that the skin of woman emits wavelengths of 9,440 millimicrons and thereby received some transmutation of energy? In other words, we want to know how one can remain in a skin game for fifty-six years and get away with it so well.

Whatever the reason be, we pause tonight to pay you tribute for your accomplishment. With that in mind, we have prepared a resolution which Doctor Kelly will submit to a vote here this evening. The following resolution will be duly engraved and presented to you as a constant reminder in the years to come, of the words of the Roman poet, Ovid, that "Time is generally the best medicine."

HAROLD M. F. BEHNEMAN.

* * *

RESOLUTION

WHEREAS, Our friend and colleague, Douglass W. Montgomery, has not only continuously and successfully practiced medicine in this city for over fifty years, but is still energetically pursuing that art according to the ethics and oath of Hippocrates; be it

Resolved, That *his* friends, the members of the San Francisco County Medical Society, herein acknowledge that unusual accomplishment, and offer to him their heartfelt felicitations and sincere good wishes for continued health and happiness.

* A Tribute: Given at a meeting of the San Francisco County Medical Association on December 14, 1937.

PACIFIC COAST ABORTION RING: CALIFORNIA SUPREME COURT DECISION*

Opinion follows:

89 Cal. App. Dec. 393—No. 3322.

Los Angeles—Arthur Crum, Judge.

Crim. No. 4116. In Bank. November 26, 1937

The People of the State of California, Plaintiff and Respondent, vs. R. L. Rankin, George E. Watts, John A. Creeth, J. O. Shinn, William A. Byrne, Valentine St. John, H. L. Houston, Bessie McCarthy, Grace Moore, Lillian Wilson, Jessie Radcliffe, James Beggs, Beatrice Bole, Jesse C. Ross, Violette Pellegrini, W. Norman Powers, and J. C. Perry, Defendants; William A. Byrne, Valentine St. John, James Beggs, and Jesse C. Ross, Defendants and Appellants.

For Appellant James Beggs—Clarence W. Hull; Sherman & Sherman.

For Appellant Valentine St. John—Charles A. Thomasset.

For Appellant William A. Byrne—R. E. Parsons, Jerome O. Hughes.

For Appellant Jesse C. Ross—Abe Richman.

For R. L. Rankin and William A. Byrne—Rosecrans & Emme, Bayard R. Rountree.

For Appellants—Anna Zacsek.

For Respondent—U. S. Webb, Attorney-General; Bayard Rhone, Deputy Attorney-General; Buron Fitts, District Attorney; Verne L. Ferguson, Deputy District Attorney.

This cause was taken over after decision in the District Court of Appeal of the Second Appellate District, Division Two, in order that we might more fully examine the record and certain issues raised upon the appeal. An examination of the evidence, covering 1,742 pages of the reporter's transcript, compels us to agree with the conclusion of the Appellate Court that as to the appellants Beggs, Ross, and St. John there is a dearth of corroborating evidence within the meaning of Section 1111 of the Penal Code as interpreted in *People* vs. *Kempley*, 205 Cal. 441, 271 Pac. 478, and *People* vs. *Davis*, 210 Cal. 540, 293 Pac. 32. However, we cannot accept the conclusion announced by that court with reference to the contention of the appellant Byrne directed against Count 7 of the indictment. This point will be discussed later.

Therefore, with such additional comment as shall hereinafter appear, we adopt the following portions of the opinion of Mr. Justice McComb as and for the decision of this court:

"Defendants were accused by the grand jury of the county of Los Angeles of the crime of conspiracy to violate Section 274 of the Penal Code, a felony, and in eight separate counts of having committed abortions. Defendants were tried jointly before a jury, whose verdicts were:

"1. Guilty:

"(Counts, 1. 2, 5, 7, and 9): R. L. Rankin, George E. Watts, J. O. Shinn, William A. Byrne, Grace Moore, Lillian Wilson, James Beggs, Jesse C. Ross.

"(Counts 1 and 5): John A. Creeth, Valentine St. John.

"(Counts, 1, 2, and 5): Violette Pellegrini.

"2. Not guilty:

"(All counts): Jessie Radcliffe, J. C. Perry.

"Defendants H. L. Houston, Bessie McCarthy, and Beatrice Bole were not apprehended, and defendant W. Norman Powers entered a plea of guilty to Count 1 of the indictment and testified on behalf of the State.

"Defendants James Beggs, William A. Byrne, R. L. Rankin, Jesse C. Ross, and Valentine St. John alone appeal from the judgments and orders denying their motions for a new trial.

"The appeal of defendant R. L. Rankin has heretofore been dismissed at his request.

Viewing the evidence most favorable to the prosecution (*People* vs. *Dukes*, 90 Cal. App. 657, 659), the facts in the instant case are:

"Defendants R. L. Rankin and George E .Watts owned, operated, and directed a series of offices, extending from Seattle, Washington, to San Diego, California, for the purpose of illegally performing abortions. The remaining defendants, with the exception of those who were acquitted by the jury, were employed by them in various capacities in connection with the conduct of their illegal business. In the course of their business, and in pursuance of their conspiracy, abortions were performed upon Gladys Duckworth, Peggy Nowell, and Josephine Peacock, as alleged in Counts 2, 5, and 9 of the indictment.

"A.

"Each appellant urges reversal of the judgments on the ground that there is no substantial corroboration of the testimony of his accomplices to show his participation in or connection with any of the crimes of which he was convicted.

"The law is settled in California that a conviction cannot be sustained upon the testimony of an accomplice, unless it be corroborated by other evidence which tends to connect defendant with the commission of the offense charged in the indictment (Section 1111, Penal Code), and it is equally clear that the corroborative evidence necessary to comply with this requirement must of itself, without the aid of the accomplice's testimony, connect or tend to connect defendant with the commission of the offense charged. (*People* vs. *Kempley*, 205 Cal. 441, 455; *People* vs. *Janssen*, 74 Cal. App. 402, 406; *People* vs. *Rokes*, 88 Cal. App. Dec. 317, 318.)

"Applying the foregoing rules to the instant case, we find with reference to the appellants Beggs, Ross, and St. John, that, after eliminating entirely the testimony of their accomplices, the record is completely devoid of any evidence even slight, which connects or tends to connect any of them with any of the crimes of which they were convicted. Since the judgments as to these appellants must be reversed for the foregoing reason, it is unnecessary for us to consider the other contentions which they have advanced.

"With reference to appellant William A. Byrne, we find a different situation. An examination of the record discloses that, after eliminating the testimony of his accomplices, there was substantial evidence considered in connection with such inferences as the jury may have reasonably drawn therefrom to connect him with the commission of the offense charged, thus furnishing the necessary corroboration to the testimony of his accomplices. One example of such corroborative evidence is found in the testimony of Geraldine Gerding, secretary to the manager of the Ocean Center Building in Long Beach, who it is conceded was not an accomplice, to the effect that appellant Byrne, about July 29, 1936, paid rent for rooms used by some of his coconspirators in that city for the purpose of performing abortions. There is ample evidence of a similar nature; however, since no useful purpose would be subserved by setting the same forth *in extenso*, we refrain from further discussion of it. (*Thatch* vs. *Livingston*, 13 Cal. App. [2d] 202, 56 Pac. [2d] 549; *Koberle* vs. *Hotchkiss*, 8 Cal. App. [2d] 634, 48 Pac. [2d] 104; *Leavens* vs. *Pinkham & McKevitt*, 164 Cal. 242, 245, 128 Pac. 399.)

"B

"Appellant Byrne relies for reversal of the judgments upon these additional propositions:

"First: Count 7 of the indictment did not charge a public offense.

"Second: Section 274 of the Penal Code is unconstitutional in that it fails to inform a person charged there-

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* Letter which follows gives additional information concerning the California Supreme Court decision in the case:

DEPARTMENT OF PROFESSIONAL AND VOCATIONAL STANDARDS
BOARD OF MEDICAL EXAMINERS
STATE OF CALIFORNIA

San Francisco, Calif.,
December 10, 1937.

Re: *People vs. R. L. Rankin, et al.* (Pacific Coast Abortion Ring).

To the Editor:—We enclose herewith galley proof of the California Supreme Court decision in the case of *People* vs. *Rankin*, wherein you will note that new trials have been granted Drs. James Beggs, Jesse C. Ross, and Valentine St. John. You will also note that the State Supreme Court sustained the Los Angeles Superior Court conviction of William A. Byrne, former Assistant Special Agent of the Board of Medical Examiners.

We believe that the decision is of sufficient importance to warrant publication in the next issue of CALIFORNIA AND WESTERN MEDICINE.

Would appreciate return of galley proof when same has served your purpose.

With kindest personal regards, believe me

Very truly yours,
(Signed) C. B. PINKHAM, M.D.,
Secretary-Treasurer.

under with reasonable certainty as to what acts or actions are prohibited by it. . . .

"Appellant Byrne's final proposition is untenable. His entire argument is directed to the point that the words 'procure the miscarriage of such woman' do not convey a definite and certain meaning. 'Miscarriage' is thus defined in Bouvier's Law Dictionary, Volume 2, page 2221:

" 'The expulsion of the ovum or embryo from the uterus within the first six weeks after conception. Between that time, and before the expiration of the sixth month, when the child may possibly live, it is termed abortion. When the delivery takes place soon after the sixth month, it is denominated premature labor. But the criminal act of destroying the fetus at any time before birth is termed, in law, procuring miscarriage.'

"An almost identical definition will be found in Cyclopedic Law Dictionary, page 662, and substantially the same definition is given in each of the modern dictionaries of the English language. It is, therefore, evident that the phrase as used in the statute was sufficiently explicit to inform persons of common intelligence and understanding of the acts which were prohibited."

Even if we concede for present purposes that Count 7 of the indictment, as urged by the appellant Byrne, is deficient because of its failure to charge the aborting of a "pregnant" woman, we are of the opinion that no prejudice resulted therefrom, inasmuch as the evidence adduced upon the trial established the pregnancy of the woman involved. Therefore, under Section 4½ of Article 6 of the Constitution the assumed defect is insufficient to warrant a reversal of the judgment. (*People* vs. *Bonfanti*, 40 Cal. App. 614, 181 Pac. 80; *People* vs. *Buttulia*, 70 Cal. App. 444, 233 Pac. 401.) In the *Bonfanti* case, *supra*, the defendant was charged with assault with intent to commit rape, but the information failed to allege, as specified in Section 261 of the Penal Code, that the woman whom the defendant had assaulted was not his wife. The evidence, however, definitely indicated that she was not his wife. Under the circumstances, it was held that the defect in the information was not prejudicial in the light of Section 4½, *supra*. The reasoning of that case is applicable here, and the contention of the appellant Byrne with respect to Count 7 of the indictment does not call for a reversal of the judgment thereon.

The judgment and orders denying the motions for new trial relative to the appellants James Beggs, Jesse C. Ross and Valentine St. John are and each is reversed, and a new trial is ordered.

The judgments and orders relative to William A. Byrne on Counts 1, 2, 5, 7, and 9 are and each is affirmed.

WASTE, C. J.

We concur: Houser, J., Shenk, J., Curtis, J., Edmonds, J., Seawell, J.

MEDICAL CLINICS PLAN: PUBLIC HEALTH EXHIBITS

Golden Gate International Exposition: San Francisco

In the huge Hall of Science at the 1939 Golden Gate International Exposition, thirty of America's leading research laboratories will tell the story of the remarkable recent progress which has been made in the prevention and treatment of disease.

Led by such world-famous institutions as the Mayo Clinic, the Jackson Clinic, the American Medical Association, and the American Society for the Control of Cancer, these laboratories will present a dramatic picture of the latest advances in medicine and its related fields. The exhibit plans will also have the coöperation of the country's leading universities, notably the University of California, Stanford University, the California Institute of Technology, University of Southern California, Harvard University, University of Oregon, and the University of Washington.

According to Milton Silverman, Director of the Hall of Science for the $50,000,000 World's Fair of the West, these exhibits will place the major emphasis on the prevention of disease rather than its treatment. Following a 9000-mile trip to the outstanding laboratories and clinics of the United States, Silverman reports that amazing exhibits are being planned to illustrate the tremendous strides which are being made in research and disease prevention.

Reservations for space in the Hall of Science have already been made by the Mayo Clinic of Rochester, Minnesota, and plans are under way for a complete research exhibit at the Fair under the direction of Dr. Charles Mayo, Dr. Donald Balfour, who is now active head of the Mayo Clinic, and Dr. Walter Alvarez, internationally famous physiologist.

Supervised by Doctor Alvarez, a new and improved model of the transparent man will be shown, particularly emphasizing the digestive apparatus of the human being. From the extensive scientific museum at Rochester will come many astonishing displays built for use at the Exposition. Other material especially prepared for the Fair, will show the remarkable technique which has been attained in plastic surgery. Displays showing the prevention and treatment of appendicitis have also been promised, and educational exhibits pertaining to diabetes, asthma and experimental dentisry are also contemplated. The Mayo Clinic will also participate in the cancer exhibit and the embryological exhibit.

The Jackson Clinic of Madison, Wisconsin, will center all its efforts on one central exhibit, the story of the thyroid gland. This display will show the normal activity of the gland and how it secretes the amazing and highly powerful hormone, thyroxin. Special consideration will be given to the remarkable achievement in preventing both physical and mental destruction through the impairment of this gland and the importance of iodin in keeping the gland functioning. Attention will also be focused on the so-called goiter belt stretching across northern United States, and dynamic exhibits will demonstrate the prevention of goiter and cretinism. Dr. Arnold Jackson, head of the clinic, will personally direct these activities at the San Francisco Exposition.

Two Wisconsin schools planning to participate in the medical exhibit are the Marquette University and the University of Wisconsin. Dr. Eben J. Carey of Marquette, who was in charge of medical exhibits at the Century of Progress, is heading a group which is planning an outstanding exhibit on embryology, "How Life Begins."

At the University of Wisconsin an exhibit is being prepared to show the modern use of drugs and chemical to alleviate pain. In a coöperative exhibit, University of Wisconsin pharmacologists and anesthetists will collaborate with similar groups from the University of California in a demonstration of modern anesthesia.

An unusual cancer exhibit, which will illustrate the steps being taken to check this most dreaded of all diseases, will have the coöperation of the American College of Surgeons and other noted groups. Use of radium, x-ray, and surgical treatment will be demonstrated as well as modern preventive measures.

Other important subjects to be covered by the American College of Surgeons include the treatment of bone injury, particularly the new plastic bone surgery. Directing the American College of Surgeons' activities at the Exposition will be a committee composed of Dr. Howard Naffziger of the University of California, president-elect of the Association; Dr. Frank Lynch, also of the University of California, vice-president; Dr. Emile Holman of Stanford University; and Dr. Malcolm McEachern of Chicago.

The story of teeth and their connection with general health will be vividly portrayed in the Hall of Science by the exhibit of the American Dental Association. As a central feature of these booths a moving model will demonstrate in a novel way how teeth are formed and grow in the mouth. A series of illustrations will also show how apparently healthy teeth can decay and how many dental troubles can be prevented from spreading to other parts of the body, particularly the heart, kidneys, and bones. Of especial interest to the layman will be a portrayal of the history of dentistry from its earliest beginnings. The crude methods of the ancient man of brawn will be vividly contrasted with the technique of the skilled specialists of today.

Another phase of the Health and Science show will deal with the prevention of diseases transmitted from household pets and other animals to man, such as tuberculosis, rabies, and Malta fever. This section of the Exposition will be under the direction of the American Veterinary Medical Association. Prevention and treatment of disease in animals also will be included in this section of the Hall, which will be under the direction of Dr. C. M. Haring of the Veterinary Science Department of the University of California.

In still another section of the vast Hall of Science industrial chemical companies will show the contributions of modern chemistry in scientific nutrition with all its import to the health of man. Other displays by the chemical industry will show the development of synthetic plastics, compounds which are beginning to be of great importance in improving man's comfort and industrial efficiency.

From the viewpoint of the layman, the medical exhibits of the San Francisco Fair will show how the application of precautionary measures can help prevent the inception of disease and the spread of infection. Every field of medicine is being drafted to help carry out this ambitious program.

For additional information, address Golden Gate International Exposition, 585 Bush Street, San Francisco.

PROPOSED INITIATIVE: MEDICINE AND SURGERY*

Proposed Initiative Law: Sponsors Hoping to Place Same on 1938 State Election Ballot

The *Attorney-General has entitled and summarized the chief purposes of the proposed amendment and the points of such* as follows:

Medicine and Surgery—Initiative.—Defines "practice of medicine" as use or prescription of poisonous drugs or medicinal preparations in treating human ailments, and remedying results of violence of accident by other than orthopedic surgery, excluding from definition all other healing practices. Provides penalties for unnecessary major surgery and creates conclusive presumption that surgery unnecessary if diagnosis is erroneous or no pathology is found justifying operation. Creates conclusive presumption of unskillfulness if person operating has less than five hundred hours' academic surgical training or has taken part in less than fifty major operations. Requires prescriptions be written in English language.

* * *

The people of the State of California do enact as follows:

PUBLIC HEALTH LIABILITY ACT

An Act to protect the public health by providing terms and conditions upon which major surgery may be performed and upon which prescriptions for any substance for treatment of human beings may be issued and dispensed; providing liabilities for the advising of or the performing of unnecessary or unskillful major surgical operations on human beings; defining major surgery and minor surgery, and practice of medicine requiring reports following major surgical operations; repealing all acts or parts of acts in conflict herewith. Provides penalties for violation of Act.

Section 1. This Act *shall be known and cited as the "Public Health Liability Act."*

Sec. 2. It shall be *unlawful for any person to perform any unnecessary major surgical operation upon any human being* or to sever any tissue of a human being unnecessarily, or to advise or prescribe for any unnecessary major surgical operation or the unnecessary severance of any tissue of a human being.

Sec. 3. *An unnecessary major surgical operation* is conclusively presumed where no pathology is found to exist which would justify a major surgical operation as performed, or a major surgical operation performed in pursuance of a wrong diagnosis, or a major surgical operation performed from which the patient could not reasonably be expected to receive the relief of disorder upon which the operation was promised.

Sec. 4. It shall be *conclusively presumed that a major surgical operation was unskillfully performed* unless the person so performing the said operation has had at the time of performing the said operation not less than five hundred hours of training in the subject of major surgery in a duly chartered college of healing; or, who at the time of the adoption of this Act attended and took part in not less than fifty major surgical operations prior to adoption of this Act; or if from the results of the said operation it is proved that the person performing the said operation did not have the necessary skill or training requisite to perform such an operation.

Sec. 5. *Nothing in this Act shall be construed as justifying any person for the negligent performance of any major surgical operation* regardless of skill or training.

Sec. 6. *A wrong diagnosis* is hereby defined to be a wrong conclusion relative to a major surgical procedure, or a wrong conclusion respecting the nature or character of the patient's condition, or a wrong determination of the existing pathology in the patient.

Sec. 7. *The burden of proof of proper training,* experience, skill and diagnosis shall be upon the person performing the said operation as a matter peculiarly within the knowledge of the said person.

Sec. 8. *Before performing any major surgical operation,* the person advising, if he is not to personally perform the said operation, and in any case the person who is to perform the said operation shall sign a written diagnosis of the patient's condition and the necessary purpose of the proposed operation in detail and shall deliver a copy of the said diagnosis and purpose of the proposed operation to the patient or his designated representative. The said writing shall be fully descriptive, definite, and certain. Any waiver or modification of this provision shall be void.

Sec. 9. *Immediately following the performance of any major surgical operation,* and in not more than five days thereafter, the person performing the said operation shall forward all, and each and every part, of excised normal or pathological tissue removed from the patient in the said operation to the State Department of Public Health, together with a copy of the surgical record. It shall be the duty of the said State Department of Public Health to examine the said tissue and to make a full and complete laboratory and other indicated report of findings from the specimens and tissue received. The making of a false report, or the making of an incomplete report as required herein shall be a violation of the Act. The report herein required shall be delivered to the patient or any designated representative in not more than twenty days after receipt of the said tissue, and there shall be no charge for the said report beyond the actual cost thereof.

Sec. 10. The said *Department of Public Health shall retain the said tissue in proper state of preservation* for a period of three hundred days unless that at any time before disposal of the said tissue or specimens on written demand, it shall deliver the same to any laboratory designated by the patient or his authorized representative. The patient may have a professional representative present during the examination of the aforesaid tissue by the said Department of Public Health.

Sec. 11. *Provided, however, that where it appears that an emergency exists* in fact the provisions of Section 8 shall not need be complied with prior to the operation, but that the said diagnosis shall be filed within forty-eight hours after the said operation has been performed. An emergency is defined to be the result of a traumatism or a condition existing that could not normally be calculated upon. Provided further, that, where this emergency provision is proved to have been used as a subterfuge to avoid

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* For further comment concerning this proposed law, the sponsors of which are seeking approval from Public Health Committees of Chambers of Commerce and other organizations, see in this issue, on page 5.

The copy of this Initiative came into our hands as the manuscripts for the January issue of CALIFORNIA AND WESTERN MEDICINE were going forward to the printer. For the information of California Medical Association members the letter which was received by members of the Public Health Committee of the Los Angeles Chamber of Commerce is printed below. In the text of the Initiative, the italics have been inserted by the Editor, to permit easier reference.† Letter to the committee members follows:

LOS ANGELES CHAMBER OF COMMERCE

Los Angeles, California,
December 16, 1937.

To All Members of the Public Health Committee,
Los Angeles Chamber of Commerce.
Dear Committee Member:

A special meeting of the Public Health Committee will be held at 12:15 p. m. on Wednesday, December 22, at the Los Angeles Chamber of Commerce, for the purpose of discussing the Public Health Liability Act, Initiative Petition No. 29.

Mr. Frank W. Walden has been invited to meet with the committee at this time, as well as a number of other interested individuals.

This is an important matter, and I hope that all committee members will be present.

Very sincerely yours,
LOS ANGELES CHAMBER OF COMMERCE.
Geo. H. Cecil,
Secretary, Public Health Committee.

† Later memo: On Wednesday, December 22, the Public Health Committee of the Los Angeles Chamber of Commerce voted to recommend nonapproval of this proposed initiative law.

any other provision of this Act, the liability and penal provisions of this Act may be doubled in the sound discretion of the court and within the provision of the law appertaining.

Sec. 12. *Major surgery is defined* as that form of surgery in which it is necessary to penetrate healthy tissue in order to reach morbid or diseased tissue. Morbid tissue shall be understood to include fractures or injured tissue due to traumatism.

Sec. 13. *Minor Surgery is defined* as that form of surgery in which it is not necessary to penetrate healthy tissue in order to reach morbid or diseased tissue. It shall be understood that penetration of healthy tissue when such penetration is limited to the subcutaneous shall be within minor surgery.

Sec. 14. The *practice of medicine is defined* to be the use or prescription of drugs or what are known as medicinal preparations for human beings and those things that are incidental thereto; and remedying as far as possible the results of violence and accident by other than orthopedic surgery, all other practices are declared not to be within the practice of medicine.

Sec. 15. The *term "drug" is defined* to mean any substance, vegetable, animal, or mineral, simple or compounded, in the composition of medicine or what are known as medicinal preparations.

Sec. 16. *"Medicine" or what are known as "medicinal preparations" is defined* to mean any drug or combination of drugs applied, prescribed, or to be used for the purpose of curing, mitigating, or alleviating physical or mental disease of human beings. The application, prescription or use of nonpoisonous substance, vegetable or animal, simple or compounded, shall not be construed as medicine or what are known as medicinal preparations, oils, liniments, or aromatics used for external purposes, shall not be construed to be medicine or what are known as medicinal preparations.

Sec. 17. *Every person who takes part in or assists,* in any manner whatsoever, in any unnecessary surgery as herein set forth, shall be equally liable as a principal, except that any nurse or student nurse having no knowledge of the lack of necessity of the said operation shall be relieved of all liability as herein provided; every hospital or institution, or hospital or institutional corporation, charitable or otherwise, which permits any unnecessary operation as herein defined, in its hospital or institution, shall be equally liable as a principal.

Sec. 18. *That every person, institution, hospital, institutional or hospital corporation,* violating any of the provisions of this Act *shall be civilly liable for the actual damages suffered and an additional sum of $500.*

Sec. 19. *It shall be unlawful for any person to issue a prescription* for any substance for any disease, deformity, or mental or physical condition of any human being, whether such substance shall be what are known as drugs or medicinal preparations or otherwise, *in other than the English language,* or to use or dispense any such prescription unless reduced to writing in the English language; or to issue or dispense any substance under a prescription which does not contain upon the container thereof a label setting forth a copy of the prescription in full, and if the said prescription be for what is known as a patent medicine, the label shall state "this prescription is for a patent medicine" and the name of the patent medicine. Nothing in this section shall be construed to prohibit the use of a language other than English, when made in addition to the English language and constituting a fair interpretation thereof.

Section 20. Any action under the provision of this Act shall be commenced within one year of the time the liability was incurred.

Sec. 21. *In the event that any person convicted under the provisions of this Act is licensed to practice any of the professions characterized as a healing art,* the board or boards of examiners of any such healing art shall suspend the license to practice of the person so convicted for not less than six months, nor more than two years. It shall be a violation of this Act for such person to practice during such suspension.

Sec. 22. *Any violation of the provisions of this Act shall constitute a misdemeanor and shall be punished by imprisonment in the County Jail for a period of not more than six months, or by a fine of not more than $500, or by both such fine and imprisonment.*

Sec. 23. All Acts or parts of Acts in conflict therewith are hereby repealed.

Sec. 24. Any section, subsection, sentence, clause or phrase of this Act for any reason held to be unconstitutional, such decision shall not affect the validity of the remaining portions of this Act. The people hereby declare that they would have passed this Act, and each section, subsection, sentence, clause or phrase thereof, irrespective of the fact that any one or more sections, subsections, sentence, clause or phrases may be declared unconstitutional.†

INFORMATION CONCERNING NEW LABORATORY LAW*

1. A *clinical laboratory* is any place or establishment where any tests, no matter how limited in variety, are made for the investigation of the existence or progress of disease.

2. A *technologist* is a person who directs a laboratory and who holds a license as a technologist.

3. A *technician* is a person who holds a license as technician and who works under the direction of a technologist or of a licensed physician and surgeon.

4. After January 1, 1938, no one may conduct a clinical laboratory unless he is either a technologist or a licensed physician and surgeon.

5. After January 1, 1938, no one may work in a clinical laboratory unless he is a technologist, a technician, or an apprentice.

6. A person may acquire a license as a technologist without examination, provided he has had five years' experience actually directing and at the same time working in clinical laboratories, all of which were completely equipped for, and doing work in all of the sciences of bacteriology, serology, biochemistry, parasitology and related subjects, the last year of which immediately preceding the passage of the Act must have been in California, and provided further that he makes application for the license before January 1, 1938.

7. A technologist's license may be secured by examination, further requirements being that he hold a bachelor's degree in one or more of the fundamental sciences pertaining to laboratory work, from a recognized institution and that he also possess five years' experience, one year of which has been as chief technician in a laboratory, all laboratories being of grade and standard acceptable to the Board of Public Health.

8. Certificates of licensure for clinical laboratory work of limited range will be issued without examination as provided in Section 4 of Chapter 804, to persons presenting evidence of experience in any phase of clinical laboratory work, totaling three years, had within the period of five years immediately preceding the effective date of the Act, one year of which shall have been in laboratories within the State of California. Such certificates will be issued one for each of the general divisions of the work, *i. e.*, bacteriology, serology, biochemistry, and hematology, and in special and particular instances may be issued for still more limited fields of activity, in which case the certificate will set forth particular tests that may be practiced.

The certificates issued under this provision will carry the statement that the license is issued without examination, under the provisions of Section 4 of the law. Graduates of a university recognized by the Board, who hold the A. B. degree, secured with a major in one of the medical sciences, will be credited with the first two years of the required experience, but one year's practical experience in an acceptable laboratory in California must be shown.

Application for technicians' licenses without examination must be made before January 1, 1938.

The fee for a technician's license without examination is one dollar, payable with application. The fee will be returned if the application is rejected.

9. Certificates will be issued to technicians by examination, each certificate entitling the holder to receive a license permitting him to engage in the work covered by the certificate.

† This proposed amendment does not expressly amend any existing law; therefore, the provisions are new provisions added to existing law.

* Chapter 804, California Statutes of 1937.

Besides separate certificates in bacteriology, serology, biochemistry, and parasitology, one all-inclusive certificate, called Senior Clinical Laboratory Technician, will be issued by examination, which certificate entitles its holder to be licensed to engage in all the work of a clinical laboratory.

10. All persons believing themselves eligible to receive any sort of license without examination should immediately write to the State Division of Laboratories, Berkeley, requesting forms on which to apply for the license. Owing to the short time remaining before January 1, where it appears impossible to complete the necessary investigation preliminary to the issuance of a license, a temporary license revocable at any time will be issued.

Such temporary licenses must be replaced by permanent licenses before July 1, 1938.

11. Fees. (Rule 14 of regulations.)

(a) *Clinical Laboratory Technologists.*—The fee for the certificate of license as clinical laboratory technologist shall be $10, payable with application for license without examination. If the applicant is found ineligible, the fee will be returned. The fee for examination for the certificate as clinical laboratory technologist shall be $5, payable with application, and not returnable in case of failure. If the applicant passes, an additional $5 must be paid before the certificate is issued. The annual renewal fee for license as clinical laboratory technologist shall be $10 for each year following the calendar year in which the certificate was issued, and payable within sixty days after the commencement of each calendar year.

(b) *Senior Clinical Laboratory Technicians.*—The fee for the examination and the certificate as senior clinical laboratory technician shall be $5, payable with application, and not returnable in case of failure. The license as senior clinical laboratory technician is good for the remainder of the calendar year in which issued, and must be renewed annually by the payment of a fee of $2 within sixty days after the commencement of each calendar year. A certificate as senior clinical laboratory technician will be issued without examination, but on the payment of the fee of $5, to all persons holding the four certificates of proficiency (Senior Grade in the old series) issued by the Board. In cases where an examination has been paid for in the securing of individual certificates, credit for such payments will apply on the fee for the issuance of the full certificate as senior clinical laboratory technician.

(c) *Certificates of Proficiency.*—These certificates, one in each of the subjects of bacteriology, serology, biochemistry, and parasitology, will be issued by examination in these subjects separately. The fee for the examination in any one subject and for the certificate and license good for the remainder of the calendar year is $2, not returnable in case of failure.

Persons now holding one or more certificates of proficiency will be issued licenses for the activities covered by the certificates which they hold. If an application for license without examination is filed, it may be found possible to include in the license issued other activities not covered by the certificate of proficiency held by the applicant.

A license in parasitology is given only by examination. The license as senior clinical laboratory technician is not given without examination except to holders of four certificates.

12. The law does not require technicians working in a doctor's office to be licensed unless work is done for other doctors or for the patients of other doctors.

13. The exemption of nonprofit hospitals, provided for in Section 6 of the law applies only to hospitals maintained by corporations for the benefit of their own employees, the hospitals being supported by "dues or contributions from employees of a common employer, or a group of affiliated employers. . . ."

14. The renewal fee for certificates of proficiency is fifty cents each, payable annually. A pocket license card is issued upon payment of the fee. Renewals and licenses for 1938 will be ready for distribution early in November.

15. Holders of four certificates of proficiency may exchange them for a senior clinical laboratory technician's certificate, or, if they meet certain other requirements, for a technologist's license.

ELIXIR SULFANILAMIDE—MASSENGILL*

Report of the United States Secretary of Agriculture

During September and October of 1937 at least seventy-three persons died as a direct result of taking the drug known as "Elixir Sulfanilamide." Twenty other persons who took the "elixir" died, but it has not yet been established that this drug was exclusively responsible. The ninety-three deaths occurred in fifteen states, as far east as Virginia, as far west as California.

"Elixir Sulfanilamide" was manufactured and sold by the S. E. Massengill Company of Bristol, Tennessee. According to the firm's books, 240 gallons were manufactured. The entire amount has been accounted for.

Before the "elixir" was put on the market, it was tested for flavor but not for its effect on human life. The existing Federal Food and Drugs Act does not require that new drugs be tested before they are placed on sale.

"Elixir Sulfanilamide" was first distributed commercially on September 4, 1937, and continued to October 15, 1937. The first word of deaths from an unidentified sulfanilamide preparation reached the Food and Drug Administration on October 14. On October 16 an investigator for the Administration telegraphed from Tulsa, Oklahoma, that nine persons had died there after taking "Elixir Sulfanilamide." Seizure of all outstanding shipments was immediately ordered.

Since the Federal Food and Drugs Act contains no provision against dangerous drugs, seizures had to be based on a charge that the word "elixir" implies an alcoholic solution, whereas this product was a diethylene glycol solution. Had the product been called a "solution," rather than an "elixir," no charge of violating the law could have been brought.

Of the 240 gallons manufactured, 228 gallons and 2 pints have been seized under federal and state laws, destroyed, collected as laboratory samples, or wasted by spillage and breakage. Eleven gallons and six pints were dispensed on prescriptions or over-the-counter sales. Of this amount, about half was consumed and caused the deaths; the other half was retrieved before consumption.

The lethal effect of the "elixir" was due to its content of diethylene glycol, which was used as a solvent in making a liquid preparation of sulfanilamide, usually administered in tablet or powder form. Sulfanilamide itself is a valuable drug, and was not responsible for the disaster.

Sulfanilamide is the name of one of a group of closely related chemicals first reported in European medical literature of 1935 to have been used for drug purposes. It has shown dramatic curative effects. Physicians in this country have been quick to recognize its far-reaching possibilities. Its use has grown to tremendous proportions. An editorial from the *Journal of the American Medical Association* stated that sulfanilamide is potentially dangerous, but that properly used it may be brilliantly successful in treating various infections.

The fatal "elixir" was rushed onto the market without adequate test to determine whether or not diethylene glycol may be safely used as a solvent for sulfanilamide, despite previously published reports in scientific literature showing that diethylene glycol might be dangerous when taken internally. A few simple and inexpensive tests on experimental animals would have quickly demonstrated the toxic properties of both diethylene glycol and the "elixir."

It will be observed that the preparation is a semi-secret one, that the presence of diethylene glycol is not disclosed, and that no warning of danger appears.

Most of the drug was administered on physicians' prescriptions.

HOW THE "ELIXIR" WAS PRODUCED

For some time before putting "Elixir Sulfanilamide" on the market, the S. E. Massengill Company had been marketing sulfanilamide in capsule and tablet form. In June, 1937, the firm's salesmen reported a demand for the drug in liquid form. Near the end of July, Mr. Watkins,

* Submitted to Congress at Washington, D. C., in response to House Resolution 352 of November 18, 1937, and Senate Resolution 194 of November 16, 1937.

See also editorial comment in December CALIFORNIA AND WESTERN MEDICINE, on page 366. For list of United States Senators and Representatives, to whom letters may be sent, in favor of revision of Federal Food and Drug laws, see in this issue on page 71.

chief chemist of the Massengill Company, according to his own statement, undertook the problem of finding a suitable liquid vehicle for sulfanilamide. Since sulfanilamide is insoluble in the various liquids commonly employed in making medicines, he tried a number of other solvents. Diethylene glycol was found to dissolve as much as 75 grains of sulfanilamide per fluidounce, but in that concentration it tended to separate out on chilling. Accordingly he decided upon 40 grains per fluidounce as a stable preparation and devised the following working formula:

Sulfanilamid	58½ pounds
Elixir Flavor	1 gallon
Raspberry Extract	1 pint
Saccharin Soluble	1 pound
Amaranth Solution 1-16	1½ pints
Caramel	2 fluidounces
Diethylene Glycol	60 gallons
Water q. s.	80 gallons

According to Mr. Watkins no tests were made to determine the toxicity of either the separate ingredients or of the finished product, or to determine by well-known methods available for the purpose whether or not the sulfanilamide decomposed in the diethylene glycol. The so-called control laboratory merely checked the "elixir" for appearance, flavor, and fragrance. Doctor Massengill confirmed Mr. Watkins' statement that no experimental animals were used or clinical tests of any kind made to determine either the effectiveness or the toxicity of the drug before it was put on the market.

THE FOOD AND DRUG ADMINISTRATION STEPS IN

The first word of deaths from an unidentified sulfanilamide preparation reached the Food and Drug Administration on October 14, 1937, through a telephone call from a New York physician associated with a large drug manufacturing concern. He repeated advices, presumably received through professional or trade contacts, that fatalities had occurred at Tulsa, Oklahoma.

Immediately instructions to investigate the report were issued by telegraph to the Kansas City station of the Food and Drug Administration, which is the nearest station to Tulsa. A representative of the Administration arrived in Tulsa the following day. He reported by telegraph on Saturday, October 16, that nine deaths had already occurred in Tulsa, including eight children with streptococcic sore throat and one adult with gonorrhea, and that all had taken a product labeled "Elixir Sulfanilamide. The S. E. Massengill Company, Manufacturing Pharmacists, Bristol, Tennessee."

Shipping records showed that the suspected "elixir" had come from a Massengill establishment in Kansas City, to which the station immediately sent inspectors. Also an inspector from the Cincinnati station, which is the nearest station to Bristol, and a medical officer from the Administration's headquarters at Washington, were sent at once to Bristol.

It was found that some of the "elixir" had been made at the Kansas City branch factory and that supplies had been sent to the New York and San Francisco sales branches. Immediately inspectors from the New York and San Francisco stations were assigned to investigate distributions from these points.

It was learned that the Massengill Company, following reports of the poisonous effects of the "elixir," had sent out approximately 375 telegrams from Bristol and additional telegrams from its branch houses totaling, according to the firm's statement, some 1,100 in all, requesting the return of outstanding shipments.

On or about October 15, on telegraphed instructions from the Bristol office, the San Francisco branch of the firm instructed its salesmen to have outstanding stocks returned. However, investigation revealed that no attempt had been made by that branch to communicate directly with dealers and doctors.

The telegrams and letters sent out by the Massengill Company gave no indication of the dangerous character of the product and were not calculated to impress receivers with the emergency character of the call for returning the goods, the inspector assigned to the Bristol office insisted that the firm issue the following telegram, dated October 19, to all persons who were listed as having received shipments of the "elixir" from Bristol:

> Imperative you take up immediately all Elixir Sulfanilamide you dispensed. Product may be dangerous to life. Return our expense.

Following similar insistence by the San Francisco, Kansas City, and New York inspectors, the branches at those points sent the following or similar telegrams to all consignees, on or about October 19:

> Imperative you take up immediately all Elixir Sulfanilamide you may have dispensed. Product may be dangerous to life. Return all stocks our expense.

As a result of these telegrams large quantities of the "elixir" was returned to the manufacturer's establishments and there taken under local or federal control. But the extremely dangerous character of the drug necessitated the most searching check to guarantee, as far as humanly possible, its complete apprehension. Practically the entire field force of 239 Food and Drug Administration inspectors and chemists were assigned to the work. They had the wholehearted and effective coöperation of state and local food, drugs, and health authorities. As an additional aid, warnings by newspaper and radio were broadcast.

In spite of the manufacturer's telegrams many shipments were found still in dealers' hands. Innumerable prescriptions filled from these lots, as well as from shipments returned to the manufacturer, were found to have been only partly consumed by the patient and so were recovered.

EFFECTS OF THE DRUG

The victims of the "elixir" were ill from about seven to twenty-one days. They suffered intense pain. All exhibited very much the same symptoms: stoppage of urine, severe abdominal pain, nausea and vomiting; stupor; convulsions preceded death in some cases. Many persons who took the drug discontinued its use with the onset of unfavorable symptoms and recovered. One person took as much as seven and one-half fluidounces without ill effect. One child died from less than two fluidounces.

LIMITATIONS OF THE LAW

As indicated earlier in this report, the only basis of action under the Food and Drugs Act against the interstate distribution of the "elixir" was the allegation that the word implies an alcoholic solution, whereas the product was a diethylene glycol solution. The fact that the law contains no specific definition of "elixir" may be responsible for Doctor Massengill's statement in his letter to the American Medical Association, carried in the press of November 3: "I have violated no law."

Most drug manufacturers recognize a responsibility to the public far greater than that imposed by existing law. Some are known to have considered making a solution of sulfanilamide in diethylene glycol before the "elixir" was put on the market, but abandoned the idea on investigating the toxicity of the solvent. But the attitude of some drug makers is exemplified in Doctor Massengill's statement carried by the press on October 23:

> My chemists and I deeply regret the fatal results, but there was no error in the manufacture of the product. We have been supplying legitimate professional demand and not once could have foreseen the unlooked-for results. I do not feel that there was any responsibility on our part. The chemical sulfanilamide had been approved for use and had been used in large quantities in other forms, and now its many bad effects are developing.

That evidence of possible danger from the internal administration of diethylene glycol was available prior to the marketing of the "elixir" is easily shown.

That a few simple tests on experimental animals would have demonstrated the lethal properties of the elixir is evident from the work reported by the American Medical Association. These results were confirmed independently by the Division of Pharmacology of the Food and Drug Administration in work yet unpublished.

While the "elixir" incident has been spectacular and has received much publicity, aside from the brevity of the period in which the killings occurred, it is but a repetition of what has frequently happened in the past in the marketing of such dangerous drugs as dinitrophenol, cinchophen, and other toxic substances.

It is worthy of note that, shocking as these instances have been, the actual toll in deaths and permanent injury from potent drugs is probably far less than that resulting from harmless nostrums offered for serious disease conditions. In these cases the harmful effect is an indirect one.

Sick people rely on false curative claims made for worthless concoctions, and thus permit their disease to progress unchecked. It may be too late when they lose confidence in the nostrum and seek rational treatment.

RECOMMENDATIONS FOR LEGISLATION

To protect the public from drugs which, like the "elixir," are dangerous because of their inherent toxicity, it is the Department's recommendation that legislation be enacted to provide at least the following:

1. License control of new drugs to insure that they will not be generally distributed until experimental and clinical tests have shown them to be safe for use. The definition of what constitutes a new drug should include (*a*) substances which have not been used sufficiently as drugs to become generally recognized as safe, (*b*) combinations of well-known drug substances where such combinations have not become generally recognized as safe, and (*c*) well-known drug substances and drug combinations bearing label directions for higher dosage or more frequent dosage or for longer duration of use than has become generally recognized as safe.

Exemption should be made for new drugs distributed to competent investigators for experimental work. A board of experts should be provided who will advise the Secretary of Agriculture on the safety of new drugs.

It is the Department's view that no other form of control will effectively safeguard the public from the dangers of premature distribution of new drugs. To increase the penalties for violations and to require label disclosure of ingredients would be helpful, but by no means fully adequate.

In the interest of safety, society has required that physicians be licensed to practice the healing art. Pharmacists are licensed to compound and dispense drugs. Electricians, plumbers, and steam engineers pursue their respective trades under license. But there is no such control to prevent incompetent drug manufacturers from marketing any kind of lethal potion.

2. Prohibition of drugs which are dangerous to health when administered in accordance with the manufacturer's directions for use. This would provide a more appropriate basis of action than that on which proceedings were instituted against the "elixir." A number of dangerous drugs are now on the market against which not even a trivial charge of violation can be made.

3. Requirement that drug labels bear appropriate directions for use and warnings against probable misuse. Much injury results from insufficient directions and from lack of warning against overdosage, or administration to children, or use in disease conditions where the drug is dangerous, or possibility of drug addiction.

4. Prohibition of secret remedies by requiring that labels disclose fully the composition of drugs. Many foreign countries now impose this requirement. Many drugs manufactured in the United States are exported to such countries under labels bearing such disclosure. The same drugs are sold to our citizens under labels that give no hint of their composition.

The physician, and the consumer who acts as physician to himself, both have a right to know what they administer.

Many poisoning cases result from choice of the wrong bottle from the home medicine cabinet, or from bottles left within the reach of small children. In such cases attending physicians are able to proceed intelligently and administer the proper antidotes or other treatment only if labels carry full disclosure of composition. Delays in obtaining this information by communicating with the manufacturer may often mean the difference between life and death.

Physicians are also handicapped in arriving at a correct diagnosis and beginning appropriate treatment when patients come to them after unsuccessful attempts at self-medication with secret remedies. The effect of such remedies may give rise to symptoms leading to erroneous diagnosis. But even if the diagnosis is correct, the kind of treatment to be used may depend upon what the patient has been taking. Again, in such circumstances, label declaration of composition may mean the difference between life and death.

The foregoing recommendations are limited to provisions which the Department believes should be enacted to safeguard the public from the dangers of drugs of one type. That type includes the inherently toxic drugs, such as the "elixir," dinitrophenol, and cinchophen. Many additional points should be considered if adequate protection is to be extended against even more widespread dangers to health and other abuses of public welfare arising from the inadequate control authorized by the present law over various other types of drugs.

PUBLIC HEALTH IS MAJOR EFFORT OF FEDERAL FOOD AND DRUG ADMINISTRATION*

Control of food and drug adulterations having a direct bearing on public health continued to require the major efforts of the Food and Drug Administration in the last fiscal year, according to the annual report of W. G. Campbell, Chief of the Administration.

Mobilization of an emergency force to follow the 1937 flood in the Ohio Valley and protect residents from food contaminated by flood waters was one of the conspicuous services by the Food and Drug Administration in the last year. Many of the forty-four federal food men assigned to the work had had experience in the 1936 flood. They were assisted by about eighty men from state and city food inspection organizations and from other federal agencies. The emergency organization functioned promptly. Work programs were under way in some areas before the flood waters began to recede. These crews handled food and drug preparations enough to have supplied a city of two hundred thousand population for a full year.

Another emergency requiring quick action by many field employees arose when it was discovered that emergency fumigation with hydrocyanic gas had made dangerous a quantity of raisins and other dried fruits—about 280,000 pounds—held up at the shipping point during the maritime strike and that these had been widely distributed. Food and Drug Administration workers quickly traced and seized nearly all the contaminated food, and the use of this method of fumigation for these commodities was immediately discontinued.

FINES VARY WIDELY

Mr. Campbell comments on the 1,700 court cases terminated in the year—1,355 food cases and 345 drug cases. "Fines varied," he says, "from sums as low as $1, $2, and $5 to a maximum actually paid of $1,500. Much higher fines were imposed in several cases, but were remitted in large part by the courts. Three jail sentences imposed in connection with second offenses were also suspended and the defendants placed on probation. In pleas of guilty to the adulteration of olive oil with tea-seed oil, two defendants were each fined $6,000, but $5,000 was subsequently remitted in each case.

"Courts in general vouchsafed no explanation for the imposition of nominal penalties. In one instance of a $2 penalty for the shipment of filthy and decomposed walnuts, the court indicated that it had taken into consideration the fact that the defendant had suffered a $1,400 loss in the seizure and destruction of the shipment by the Government. In another instance dealing with a practically worthless product offered as a treatment for serious diseases of the eye, the court imposed without comment, a fine of $1 and costs of $35."

"Other courts," Mr. Campbell continues, "have indicated a growing interest in the public protection afforded by the Food and Drugs Act. In passing sentence against a spinach canner who had entered a plea of guilty to the sale of dirty canned spinach, a court remarked that if the defendant was unable to manufacture clean food he had better get out of business and stay out of that court."

ISSUES IN LEGISLATION

Discussing possible changes in the law, Mr. Campbell says: "As in the three preceding years, legislative efforts have been continued in the Congress for a more adequate food and drug law. Senate Bill 5, introduced January 6, 1937, was passed by the Senate on March 9. This bill pro-

* From the United States Department of Agriculture.

poses a comprehensive revision of the Food and Drugs Act. Other bills of similar character are H. R. 300 and H. R. 5286. H. R. 5286 is designed to amend the Federal Trade Commission Act by authorizing specific control under that Act of false advertising of foods, drugs, therapeutic devices, and cosmetics.

"At the close of the fiscal year all these measures were pending before the House Committee on Interstate and Foreign Commerce. The principal issues involved were:

"1. Should seizure action to prevent distribution to consumers of a misbranded product be limited, pending court trial of the case, to a single interstate shipment of that article, or should the authority in the present law to seize all such shipments be continued?

"2. Should seizure cases be tried, as at present, where the goods are seized, before the courts and juries of the consuming areas where the goods are intended for distribution, or should the law be changed to authorize the case to be removed to the place from which the goods were shipped and there tried before the courts and juries of producing areas?

"3. Should the misbranding provision of the present law, which prohibits labeling that is 'false or misleading in any particular' be retained, or should the standard of truthfulness thus imposed be changed to ban labels only when 'misleading in a material respect'?

"4. Should false advertising of foods, drugs, therapeutic devices, and cosmetics be controlled through injunctions and cease-and-desist orders, which carry no penalty for the initial offense or for subsequent offenses up until the date the injunction or order becomes effective, or should a deterrent to the commission of these offenses be set up by providing penalties for their initial commission?"

ENFORCEMENT OF ACT

As compared with 1936, the Administration collected more samples of food and drugs, but there were slight decreases in the totals of the criminal prosecutions and seizures. Improvement in foreign trade was reflected in an increase in the number of import samples and in time devoted to imports.

The spray residue situation has improved materially, largely because many states now meet fully the federal standards and are controlling poisonous spray residues on fruits and vegetables before the products leave the State. Federal workers analyzed more than 5,000 samples of fresh fruits and vegetables, but on incomplete returns State laboratories are known to have made more than 85,000 tests.

"Continuing the good record of several years, no authentic case of botulism from American commercially canned food was reported," says Mr. Campbell.

Both the salmon and tuna packs required considerable control last year, but the sardine and mackerel packs gave no reason for seizures. The Administration and the salmon-packing industry have worked out a new method for simplifying the control of the pack and making it more effective.

Adulteration of food with water is one of the most profitable forms of economic cheats, and one of the hardest to deal with, says the report, emphasizing the need for legal standards to establish limits on the water content of canned and bottled products.

The Administration tested the vitamin D value of nearly 900,000 gallons of imported oils—principally cod-liver oil, intended for animal feeding. About one-third was deficient in vitamin value and was excluded. In interstate tests of vitamin products, twenty-four out of thirty-four samples failed to show the vitamin values claimed for them.

Conditions are improving notably, but the campaign for cleaner cream and butter will have to be continued, the report says. It also includes records of the enforcement of several minor acts administered by the Food and Drug Administration that regulate insecticide, caustic poisons, import milk, filled milk, naval stores, tea imports, and the certification of coal-tar colors.

UNITED STATES SENATORS AND REPRESENTATIVES IN CONGRESS: FOR CALIFORNIA

With Special Reference to Federal Pure Food and Drug Law

For the information of county society secretaries and members of the California Medical Association who desire to write to the two United States Senators from California and to the Representatives from their own and other districts, the roster of congressmen is given below.

While Congress is in session, as at the time of this writing, these congressmen may be addressed as follows:

Hon. _____
Senator for California
(or Congressman for California)
Washington, D. C.

CALIFORNIA AND WESTERN MEDICINE, in its December issue, on pages 366 and 435, discussed the Federal Food and Drug laws. County societies were urged to write to congressmen. The roster below may be of service.

UNITED STATES SENATORS AND REPRESENTATIVES IN CONGRESS

United States Senators

Hiram W. Johnson (Rep.), Mills Tower Building, San Francisco.

William G. McAdoo (Dem.), Transamerica Building, Los Angeles.

Represenatives in Congress

Clarence F. Lea (Dem., Rep.), 719 North Street, Santa Rosa, First District.

Harry L. Englebright (Rep., Dem.), Nevada City, Second District.

Frank H. Buck (Dem.), Vacaville, Third District.

Franck R. Havenner (Prog.), 640 Ellis Street, San Francisco, Fourth District.

Richard J. Welch (Rep., Dem., Prog.), 978 Guerrero Street, San Francisco, Fifth District.

Albert E. Carter (Rep., Dem., Prog.), 552 Montclair Street, Oakland, Sixth District.

John H. Tolan (Dem.), 1007 Harvard Road, Oakland, Seventh District.

John Joseph McGrath (Dem., Rep., Prog.), 280 Crystal Springs Road, San Mateo, Eighth District.

B. W. Gearhart (Rep., Dem.), 857 M Street, Fresno, Ninth District.

Henry E. Stubbs (Dem.), 707 East Cypress, Santa Maria, Tenth District.

John Steven McGroarty (Dem.), Tujunga, Eleventh District.

H. Jerry Voorhis (Dem.), Valley Center, San Dimas, Twelfth District.

Charles Kramer (Dem.), 1947 North Serrano, Los Angeles, Thirteenth District.

Thomas F. Ford (Dem.), 940 North Benton Way, Los Angeles, Fourteenth District.

John M. Costello (Dem.), 2142 Canyon Drive, Hollywood, Fifteenth District.

John F. Dockweiler (Dem., Rep.), 935 South Dunsmuir, Los Angeles, Sixteenth District.

Charles J. Colden (Dem.), 2200 Alma Street, San Pedro, Los Angeles, Seventeenth District.

Byron N. Scott (Dem.), 6325 East Ocean Boulevard, Long Beach, Eighteenth District.

Harry N. Sheppard (Dem.), Box 465 Yucaipa, Nineteenth District.

E. V. Isaac (Dem.), 5380 El Cajon, San Diego, Twentieth District.

Do Not Coddle Diabetic Child, Physicians Warn.—Severe onsets of diabetes in children may be due principally to false notions and neglect in parents, in many instances. Ordinarily, diabetic children under adequate treatment are as healthy otherwise as so-called normal children, and should be treated like others of their age. They should not be singled out by the parents for special coddling or undirected home treatment, nor should they be segregated from other children or adults.

This statement is made by the Division of Pediatrics of the University of California Medical School, in an effort to decrease the disabilities of children during the acute phases of child diabetes generally.

TWENTY-FIVE YEARS AGO†

EXCERPTS FROM OUR STATE MEDICAL JOURNAL

Vol. XI, No. 1, January, 1913

From some Society Reports:

California Northern District Medical Society.—The twenty-second annual meeting was held at Elks Hall, Chico, November 19, 1912. New officers elected: President, Dr. Dan Moulton, Chico; First Vice-President, Dr. G. H. Fay, East Auburn; Second Vice-President, Doctor Peery, Yuba City; Secretary, Dr. F. F. Gundrum, Sacramento; and Treasurer, Dr. O. Stansbury, Chico.

Glenn County Medical Society.—On November 21, a first meeting was called by the physicians of Glenn County for the purpose of organizing a county medical society. Dr. J. A. Randolph was chosen temporary chairman, and Dr. F. M. Lawson temporary secretary.

Our Medical Defense.—

To the Medical Society of the State of California.
Gentlemen:

I wish to thank the Society for the manner in which it looked after the defense of the malpractice suit brought against me by J. F. Beene, who suffered from a delayed union of the radius and ulnar of the left arm. Your defense was thorough and every precaution was taken for the protection of my professional reputation, as well as my finances, and no corporation insurance company or individual could have more surely or successfully cared for and protected my interests.

I wish it were possible for the whole profession to realize the importance of having the Society back of them, as I do. Any physician is just as liable to have a suit brought against him as I was, and no better protection can be had than I got in my recent trial.

Very truly yours,
N. T. ENLOE,
Chico, Calif.

From some Editorial Notes:

Proper Reciprocity.—The "Fresno Republican," in its issue for November 21, again discusses the *Journal* of the Medical Society of the State of California and the question of medical reciprocity, and asks, "Will the *Journal* say whether it favors a reciprocity law, such as most other states have, to apply to states having equally high standards?" Most unequivocally, *yes!* Not only does the *State Journal* approve of a *proper* reciprocity law, but the State Medical Society, when it prepared the law of 1901, included in that law a reciprocity clause. Is that sufficient indication of the attitude of the Society and of its *Journal?*

* * *

Progress in Anesthesia.—The last few years have seen considerable progress in the development of improved anesthetics and improvement in the manner of producing anesthesia. It is quite a while since the spectacle of two or three husky men holding one poor patient, while another helper crowded a mask over his face, has faded away. Gwathmey has recently made a suggestion that, during the limited time it has been tried, seems to be a distinct advance in anesthesia. He begins the anesthesia with two to four drops of essence of orange (25 per cent U.S.P.), and then continues with the drop method of ether anesthesia. In a recent paper in the *Journal of the American Medical Association*, he highly commends the work of the Committee on Anesthesia of the Association, and recommends that it be continued. He also suggests that the future development in anesthesia should be along the line of some form of "vapor anesthesia."

* * *

Congresses and Clinics.—The great surgical congress recently held in New York seems, from the accounts of

(Continued in Front Advertising Section, Page 15)

†This column strives to mirror the work and aims of colleagues who bore the brunt of Association work some twenty-five years ago. It is hoped that such presentation will be of interest to both old and new members.

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA†

By CHARLES B. PINKHAM, M.D.
Secretary-Treasurer

"Los Angeles is America's No. 1 quack nest. This was the declaration of Dr. Morris Fishbein, Editor of the *Journal of the American Medical Association*, yesterday, when he addressed the fourth annual post-graduate assembly of the College of Medical Evangelists. 'It is high time State officials were driving the quacks out of business in Los Angeles,' he said. 'I have been in every city in the United States at least five times in the last two years, and I say without reservation that Los Angeles has more quacks than any other place in the country. This city is full of medical charlatans and mumbo-jumbo practitioners of all kinds. It is up to the State of California to clean up the town.' Doctor Fishbein declared medical quacks are ruining the lives of hundreds of persons every year. 'These fakers, with their lurid promises of cure-alls, are bringing sorrow and tragedy to many of our citizens,' he said. 'I urge the men and women of the medical profession to join the fight to end the widespread quackery in Los Angeles.' Doctor Fishbein addressed one thousand physicians and surgeons in Paulson Hall of White Memorial Hospital. . . . " (Los Angeles *Examiner*, December 6, 1937.) The Annual Reports of the Board of Medical Examiners for many years past verify the statements quoted. For instance, Los Angeles Special Agent Carter in his Annual Report for 1933 said, "Throughout the past year we have made continual effort to prosecute and drive from California various fakers, who, on one pretext or another, prey upon the sick and afflicted. . . . These charlatans come to California from all over the world and, strange as it may seem, they always find some poor sucker who falls for their new discovery, or machine, or method that is heralded as a sure cure for almost every ailment mankind is heir to. Apparently intelligent persons, who would think they were grossly overcharged if a regular physician charged them a $10 fee, will cheerfully pay $250 to $2,000 for a fake 'radium operation' on their eyes by a smooth-talking confidence man, whom they never saw or heard of before. . . ." The number of charlatans is so great and the majority are so well entrenched by astute legal advice, that the four investigators allowed the Board of Medical Examiners find insurmountable difficulties in endeavoring to make an impression on the host referred to. The monthly report of the Board of Medical Examiners, both North and South, speaks for itself as to the continued activities of said Board in endeavoring to protect the citizens of this State from imposition and fraud.

"Richard J. Howard, seventy-one, Hacienda rancher, was lodged in the county jail at Santa Rosa, Wednesday night, on complaint of an inspector for the State Board of Medical Examiners. He is accused of practicing medicine without a license. Arrested as Howard's assistant in what T. P. Hunter, the state investigator, termed a 'quack' cancer cure, was William P. Devine. The state official also seized a supply of patent medicines which he claimed were used by Howard, once widely known throughout Sonoma Valley as 'Doctor' Howard. The arrests were the result of an asserted course of treatment given to an aged Kenwood resident, said to be a cancer sufferer, officers said. . . . Records at the county jail show that Howard has been arrested several times in recent years for asserted violation of the State Medical Practice Act. . . ." (Petaluma *Argus-Courier*, November 11, 1937.) (Previous entries, December, 1929; June, 1932.)

"Surprise is created by the news that a sufferer from disease intrusted his case to a quack rather than to a reputable physician. One naturally wonders why anyone will take chances in a matter of such moment with persons

(Continued in Front Advertising Section, Page 20)

† The office addresses of the California State Board of Medical Examiners are printed in the roster on advertising page 6.